85-654 (1)

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1985

Supreme Court, U.S.
FILED
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JOSEPH F. SPANIOL, JR.
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No. _____

SEYMOUR ALLAN HURVITZ, MD, Petitioner

v.

DIVISION OF MEDICAL QUALITY, BOARD OF MEDICAL QUALITY ASSURANCE, DEPARTMENT OF CONSUMER AFFAIRS, STATE OF CALIFORNIA, Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEAL OF THE STATE OF CALIFORNIA, SECOND APPELLATE DISTRICT, DIVISION FIVE

S. ALLAN HURVITZ, MD
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Suite 508
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Tel.: (213) 477-5575
Petitioner In Pro Se

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TABLE OF CONTENTS

Page

Citations (Table of Authorities).....x

I. Opinion Below.....2

II. Jurisdiction.....2

III. Questions Presented.....3

1. Whether there was violation of Petitioner's right of due process of law by the California Appellate Court's decision affirming Superior Court's judgment revoking Petitioner's license to practice medicine and declaring him incompetent and grossly negligent based on the finding that the vertebral artery surgeries performed by him on 22 patients were unnecessary and inappropriate?.....3

2. Whether California Business and Professions Code (B &P) Sections 2361 (b) and (c) as applied to particular facts of this case are unconstitutionally vague and incapable of uniform enforcement, violating Petitioner's Constitutional right of due process and

equal protection of the law, and representing an impermissable delegation of legislative authority?.....4

3. Whether the California Appellate Court's decision affirming the Superior Court's judgment that Petitioner was guilty of incompetence and gross negligence and revoking his certificate to practice medicine and thereby depriving Petitioner of a valuable property right (his job and medical license) violated Petitioner's rights to due process of the law under the First, Fifth and Fourteenth Amendments to the US Constitution and denied him judicial review?.....6

4. Whether Petitioner's published and non-published ideas of medical research regarding the diagnosis of hindbrain ischemia and surgical treatment of symptomatic hindbrain ischemia with vertebral artery surgery are protected by the freedom of speech clause in the First Amendment to US Constitution and

whether his right to freedom of speech was violated by California Appellate Court, Superior Court and BMQA when they declared Petitioner incompetent and revoked his medical license?.....9

5. Whether Petitioner was denied adequate Notice under Due Process Clauses of the Fifth And Fourteenth Amendments to US Constitution of the precise and specific charges against him with loss of First Amendments Freedoms -- and whether under the Fifth And Fourteenth Amendments, The ALJ was barred from bringing new charges against Petitioner and whether the proposed decision of the ALJ which was adopted by BMQA must be limited in its adverse findings (charges) to the precise charges alleged against Petitioner by BMQA in its Accusation?.....10

6. Whether there was violation of Petitioner's right of due process of law with denial of his Constitutional right to a fair hearing before

the ALJ?.....10
IV. Law Involved.....10
V. Parties.....11
VI. Statement of Facts and Proceedings..12
VII. Reasons for Granting the Writ.....25
A. There Was Violation Of Petitioner's Right Of Due Process Of Law By California Appellate Court's Decision Affirming Superior Court's Decision Revoking Petitioner's License To Practice Medicine And Declaring Him Incompetent And Grossly Negligent Based On The Finding That Vertebral Artery Surgeries Performed By Him On 22 Patients Were Unnecessary And Inappropriate.....25
B. California Appellate Court's Decision Affirming Superior Court's Decision That Petitioner Was Guilty Of Incompetence And Gross Negligence And Revoking His Certificate To Practice Medicine And Thereby Depriving Petitioner Of A Valuable Property Right (his job and medical license) Clearly

Violated Petitioner's Rights To Due Process Of Law Under First, Fifth and Fourteenth Amendments To US Constitution And Denied Him Judicial Review.....26

C. California Business and Professions Code (B & P) Sections 2361 (b) And (c) As Applied To Particular Facts Of This Case Are Unconstitutionally Vague And Incapable Of Uniform Enforcement, Violating Petitioner's Constitutional Right Of Due Process And Equal Protection Of The Law, And Representing An Impermissable Delegation of Legislative Authority.....29

D. Petitioner's Published And Non-published Ideas Of Medical Research Regarding Diagnosis Of Hindbrain Ischemia And Surgical Treatment Of Symptomatic Hindbrain Ischemia With Vertebral Artery Surgery Are Protected By The Freedom Of Speech Clause In First Amendment To US Constitution And His Rights To Freedom Of Speech Were

Violated By California Appellate Court, Superior Court And BMQA When They Declared Petitioner Incompetent And Revoked His Medical License.....43

E. Petitioner Was Denied Adequate Notice Under Due Process Clauses Of Fifth And Fourteenth Amendments To US Constitution Of The Precise And Specific Charges Against Him With Loss Of First Amendment Freedoms -- Under Fifth And Fourteenth Amendments, ALJ Was Barred From Bringing New Charges Against Petitioner And Also Proposed Decision Of ALJ Which Was Adopted By BMQA Must Be Limited In Its Adverse Findings (Charges) To The Precise Charges Alleged Against Petitioner By BMQA In Its Accusation.....44

F. There Was Violation Of Petitioner's Right Of Due Process And Denial To Petitioner Of His Constitutional Right To A Fair Hearing Before ALJ.....48

G. BMQA's Decision Revoking Petitioner's Certificate To Practice Medicine

Was Illegal And Irrational Since Decision States That "It Would Not Be Against The Public Interest To Permit Dr. Hurvitz To Practice Medicine" And That Petitioner Is A "Qualified Board-certified Thoracic And Cardiac Surgeon" And Nowhere In Decision Does It Indicate That Petitioner Is Unfit To Practice Medicine.....49

H. There Was No Incompetence On The Part Of Petitioner In Treatment Of The Twenty-two Patients, Since Irrefutable Evidence Of Significant Partial Obstruction Of The Operated Vertebral Artery Was Found At Surgical Operation In Each Patients And Was Recorded In The Operative Reports And Was Corroborated By Testimony Of Assistant Surgeon.....50

I. There Was No Gross Negligence On The Part Of Petitioner In Treatment Of The Twenty-two Patients, Since No Patient Suffered Any Bodily Injury Or Complication As A Result Of Surgery And There

Was A Stipulation That The National Ordinary Standard Of Conduct Applied In Petitioner's Case.....52

J. Congress Intended That The Treating Physician Should Determine What Services A Patient Requires And The Named Twenty-two Patients Exercised Their Constitutional Right By Electing To Have Vertebral Artery Surgery.....56

K. All Charges In BMQA's Accusation Are False As Shown By Testimony Of Petitioner's Expert Witnesses.....57

L. BMQA's Witnesses Were Not Competent Regarding Hindbrain Ischemia And Vertebral Artery Surgery.....61

M. Petitioner Recorded Pre-operatively In Hospital Charts Of Each Patient Xray Evidence Of Partial Obstruction Of Vertebral Artery [Exh. 3A-3V].....63

N. Appellate Court's Decision Affirming Superior Court's Judgment Disregarded The Overwhelming Weight Of Evidence, Is Inconsistent With Congressional Intent, Was Not Reached Through Application Of

Proper Legal Standards, Rejected Evidence That Conflicted With BMQA's Finding of Fact, Does Not Have Reasonable Basis In Law, Applied Arbitrary Standards, Misconstrued Applicable Law, And There Were Prejudicial Abuses Of Discretion On The Part Of Appellate Court And Superior Court And BMQA And ALJ.....64

VIII. Conclusion.....65

Appendix.....A1

California Supreme Court Notification of Denial of Petition for Review...A2

Superior Court's Judgment Denying Peremptory Writ of Mandate.....A4

Opinion and Judgment of California Appellate Court A9

Adopted Decision of Board of Medical Quality Assurance.....A29

Certificate of Service.....A95

CITATIONS

I. Federal Cases: Page(s)

A. B. Small Co. v. American Sugar Refining Co. 267 US 233, 239 (1924).....32

A Quaker Action Group v. Hickel 421 F.2d 1111, 1116 (D.C. Cir. 1969).....47

American Broadcasting Companies Inc. v. Cuomo 570 F.2d 1080, 1084 (2nd Cir. 1977).....48

Anti-Fascist Comm. v. McGrath 341 US 123, 171-172 (1951).....48

Breeden v. Weinberger 377 F.Supp. 734 (D.C. La. 1974).....56

Cate v. Oldham 707 F.2d 1176, 1185-1190 (11th Cir. 1983).....47

Connally v. Gen'l Construction Co. 269 US 385, 391 (1925).....31

Eisenberg v. Mathews 420 F.Supp. 1274 (D.C. Pa. 1976).....45

Elrod v. Burns 427 US 347, 96 S.Ct. 2673, 2689-2690 (1976).....46

Federal Trade Comm. v. Carter 636 F.2d 781, 791, (D.C. Cir. 1980)...48

Goldberg v. Kelley 397 US 254 (1970).....46

Goss v. Lopez 419 US 565 (1975)...46

Grayned v. City of Rockford 408 US 104, 92 S.Ct. 2294 (1972).....31

Hathaway v. Mathews 546 F.2d 227 (7th Cir. 1976).....45

In re Gault 387 US 1 33 (1967)....48

Ivy Nursing Home v. Califano W.D. Pa. No. 77577 585 (1977).....45

Mathews v. Eldridge 44 US 319 (1976).....46

Memphis Light, Gas & Water Div. v. Craft 436 US 1, 98 S.Ct. 1554 (1978).....46, 48

Morrisey v. Brewer 408 US 471, 486-487 (1972).....48

New York Times Co. v. US 403 US 713, 91 S.Ct. 2140 (1971).....47

Pippin v. Richardson 349 F.Supp. 1365, 1369-1370 (D.C. Fla. 1972)..57

Planned Parenthood v. Citizens For Com. Action 558 F.2d 861, 867 (8th Cir. 1977).....47

Rowe v. Norton 380 F.Supp. 726 (D.C. Conn. 1974).....56

United Church, Etc. v. Medical Center Com'n. 689 F.2d 693, 700-701 (7th Cir. 1982).....47

United States v. Capital Traction Co. 34 App. D.C. 592, 598, language approved 269 US 385, 393 (1925)...32

Wolf v. McDonnell 418 US 539, 564 (1974).....48

II. United States Constitution :

Fifth Amendment 3, 6, 10, 25 26, 29

First Amendment 6, 9, 10, 26

Fourteenth Amendment ...3, 6, 10, 25 26, 29

III. California State Cases :

Anton v. San Antonio Community Hospital 19 Cal.3d 802, 140 Cal.Rptr. 442 (1977).....33, 34, 42

Barker Bros. v. Los Angeles 10 Cal. 2d 603, 609 (1938).....33

Bayside Timber Co. v. Board of Supervisors of San Mateo County 20 Cal.App.3d 1, 97 Cal.Rptr. 431 (1971).....41, 43

County of Nevada v. MacMillen 11 Cal.App.3d 662, 673, 114 Cal.Rptr. 345 (1974).....34

Ettinger v. BMQA 135 Cal.App.2d 853, 856 (1982).....23

Frank v. Municipal Court 145 Cal.App.3d 200, 193 Cal.Rptr. 299, 301 (1983).....34

Franz v. BMQA 31 Cal.App.3d 135,
181 Cal.Rptr. 732 (1982)...8, 28, 36

Gore v. BMQA 110 Cal.App.3d 184,
167 Cal.Rptr. 881 (1980).....35

Hewitt v. Board of Medical Examiners
148 Cal. 590, 592 (1906)..30, 33, 42

In re Newbern 53 Cal.App.2d 786,
797 (1960).....33

Kugler v.Yocum 69 Cal.App.2d 371,
71 Cal.Rptr. 687 (1968).....41

Morrison v. State Board of Education
1 Cal.App.3d 214, 231, 82 Cal.Rptr.
175, 187 (1969).....31, 34, 36

People v. Curtis 70 Cal.2d 347,
355 (1969).....38

People v. Daniels 71 Cal.App.2d
(1969).....34

Pollack v. Kinder 85 Cal.App.3d
833, 837 (1978).....38, 39, 40

Serrano v. Priest 5 Cal.App.3d
584 (1971).....32, 33

Shea v. Board of Medical Examiners
81 Cal.App.3d 564, 574-575,
146 Cal.Rptr. 653 (1978).....34

Van Meter v. Bent Construction
Co. 46 Cal.2d 588, 594 (1956).....35

Wilke & Holzheiser, Inc. v. Dept.
of Alcoholic Beverage Control 65
Cal.App.2d 349, 369, 55 Cal.Rptr.
23, 36 (1966).....41

Wingfield v. Felder 29 Cal.App.3d 209, 105 Cal.Rptr. 619 (1973).....31

IV. California Statutes :

Business and Professions Code:

Chapter 5 (Sec. 2000-2528.3).....5

Sections 2234 (b) and (d).....20

Section 2361 (b)...4, 5, 6, 11, 29, 35, 38, 42, 43

Section 2361 (c)...4, 5, 6, 11, 29, 38, 40, 42, 43

Section 2426.....4, 5

V. Federal Statute :

28 U.S.C. Section 1257.....2

Medicare Act.....57

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PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEAL OF THE STATE OF CALIFORNIA, SECOND APPELLATE DISTRICT, DIVISION FIVE

The Petitioner, Seymour Allan Hurvitz, MD, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the Court of Appeal of the State of California, Second Appellate District, Division Five, entered in this proceeding on May 13, 1985; Appellate Court No. B-007663.

I. OPINION BELOW

The opinion and judgment of the Court of Appeal of the State of California will not be published and appears in the Appendix hereto beginning on page A10. The judgment of the State of California Superior Court of Los Angeles County appears in the Appendix hereto beginning on page A5. The adopted decision of the California Board of Medical Quality Assurance (hereinafter "BMQA") appears in the Appendix hereto beginning on page A30.

II. JURISDICTION

The opinion and judgment of the Court of Appeal of the State of California was entered on May 13, 1985. A timely Petition for Review by the Supreme Court of the State of California was denied on July 24, 1985, and this petition for a writ of certiorari was filed within 90 days of that date. The notification of denial of the Petition for Review by the Supreme Court of the State of California appears in the Appendix hereto on page A3. This Court's jurisdiction is invoked under 28 U.S.C. Section 1257.

III. QUESTIONS PRESENTED

1. Whether there was violation of Petitioner's right of due process of law by the California Appellate Court's decision affirming Superior Court's judgment revoking Petitioner's license to practice medicine and declaring him incompetent and grossly negligent based on the finding that the vertebral artery surgeries performed by him on 22 patients were unnecessary and inappropriate?

Whether the 22 patients who had the vertebral artery surgery performed by Petitioner required the surgery or did not require the surgery must, of necessity, be a "scientific fact". Medical opinions vary. What one doctor may find necessary and appropriate, another doctor may find unnecessary and inappropriate. In our constitutional framework, we have laws that determine standards. Due process means that before an individual may be penalized for his actions, he has a right to have a law exist which gives him notice of the prohibited

conduct. Absence of such notice means a lack of due process of law.

There is no California State law setting forth standards for the indications and performance of vertebral artery surgery. Petitioner was "tried and convicted" of violating a rule of law which does not exist. Medical opinions from BMQA or any doctor are not and cannot be laws. Legal rights cannot be adjudicated upon medical opinions.

2. Whether California Business and Professions Code (B &P) Sections 2361 (b) and (c) as applied to particular facts of this case are unconstitutionally vague and incapable of uniform enforcement, violating Petitioner's Constitutional right of due process and equal protection of the law, and representing an impermissable delegation of legislative authority?

a. B & P Sections 2361 (b) and (c) are in fact penal statutes by operation of B & P Section 2426.

(1) Because of the dual nature of the charged violations (unprofessional

conduct and crimes), due process-criminal standards of certainty govern the constitutional examination of the validity of B & P Sections 2361 (b) and (c).

b. B & P Code Chapter 5 is titled "Medicine" and consists of Sections 2000 through 2528.3.

c. B & P Section 2361 states: "Grounds for action against certificate-holders. The Division of Medical Quality shall take action against any holder of a certificate, who is guilty of unprofessional conduct which has been brought to its attention, or whose certificate has been procured by fraud or mispresentation or issued by mistake. Unprofessional conduct includes, but is not limited to, the following:....(b) Gross negligence; (c) Incompetence; (d) Gross immorality...."

d. B & P Section 2426 states: "Punishment where not otherwise specific. Unless it is otherwise expressly provided, any person, who violates any provision of this chapter, is guilty of a misdemeanor and

shall be punished by a fine of not less one hundred dollars nor more than six hundred dollars or by imprisonment for a term of not less than sixty days nor more than one hundred eighty days or by both such fine and imprisonment."

e. B & P Sections 2361 (b) and (c) have not been challenged for certainty in any case resulting in a published appellate decision.

3. Whether the California Appellate Court's decision affirming the Superior Court's judgment that Petitioner was guilty of incompetence and gross negligence and revoking his certificate to practice medicine and thereby depriving Petitioner of a valuable property right (his job and medical license) violated Petitioner's rights to due process of the law under the First, Fifth and Fourteenth Amendments to the US Constitution and denied him judicial review?

a. Petitioner was entitled to judicial review of BMQA's decision.

b. Petitioner's case failed to receive judicial review because the Superior Court

Judge and Appellate Court Judges were incompetent to read and consider the 21 sets of angiographic xrays (390 xray films) which were the prime evidence. The Judges were not capable of understanding the subject matter and lacked sufficient knowledge of complex medical matters to intelligently decide the case.

(1) In his judgment denying peremptory writ of mandate which appears in the Appendix on page A7, SUPERIOR COURT JUDGE SAVITCH STATES THAT HE "read and considered sets of xrays pertaining to 21 patients". The Judge's legal incompetence to read and consider the xrays prevented the Superior Court from rendering its independent judgment on the underlying charges.

(2) The 390 angiographic xrays [Exhibit (Exh.) 3BX through 3VX] pertaining to 21 patients were extremely important evidence. "Angiography is the mainstay in evaluating cerebrovascular insufficiency" [Dye and Brown, Surgical Clinics of North America, Exh. XXX, p. 247]. "Angiography

reveals the location of suspected vascular obstructions and eliminates other etiologic possibilities" [Toole and Patel, Cerebrovascular Disorders, Exh. AAAA, p. 148].

(3) There were no markings on the 390 xrays, except on one film, resulting in an inadequate record violating the command in Franz v. BMQA 31 Cal.App.3d 135, 181 Cal.Rptr. 732 (1982) and further prevented the Superior Court Judge from rendering his independent judgment on the underlying charges.

c. At Petitioner's hearing, ALJ read and considered all of the 390 angiographic xrays and gave his own interpretation of the xrays in his proposed decision, which he was incompetent to do. Petitioner was denied a fair hearing because the trier of fact (the ALJ) did not have the educational capability of comprehending the subject matter and lacked sufficient knowledge of complex medical matters to intelligently decide the case.

d. The issue of whether Petitioner was incompetent and grossly negligent in the diagnosis and surgical treatment of 22 patients with the diagnosis of hindbrain ischemia with significant partial obstruction of the vertebral artery revolves around the 390 aortic arch angiographic xrays which visualize the arteries in the chest and neck which supply the brain with blood, including the vertebral arteries.

4. Whether Petitioner's published and non-published ideas of medical research regarding the diagnosis of hindbrain ischemia and surgical treatment of symptomatic hindbrain ischemia with vertebral artery surgery are protected by the freedom of speech clause in the First Amendment to US Constitution and whether his right to freedom of speech was violated by California Appellate Court, Superior Court and BMQA when they declared Petitioner incompetent and revoked his medical license?

a. Prior to his hearing before the ALJ, Petitioner had published four articles on

hindbrain ischemia and vertebral artery surgery in three different surgical journals.

5. Whether Petitioner was denied adequate Notice under Due Process Clauses of the Fifth And Fourteenth Amendments to US Constitution of the precise and specific charges against him with loss of First Amendments Freedoms -- and whether under the Fifth And Fourteenth Amendments, The ALJ was barred from bringing new charges against Petitioner and whether the proposed decision of the ALJ which was adopted by BMQA must be limited in its adverse findings (charges) to the precise charges alleged against Petitioner by BMQA in its Accusation?

6. Whether there was violation of Petitioner's right of due process of law with denial of his Constitutional right to a fair hearing before the ALJ?

IV. LAW INVOLVED

Federal law involved includes US Constitution and First, Fifth and Fourteenth Amendments to US Constitution. California law involved is Business and Professional

Code Sections 2361 (b) and (c).

V. PARTIES

Petitioner, SEYMOUR ALLAN HURVITZ, MD, is 55 years of age, was licensed to practice medicine in California in 1956. Petitioner is an expert in the diagnosis and surgical treatment of hindbrain ischemia, also known as vertebral-basilar artery insufficiency of the brainstem (hereinafter "VBAI"), and as of date of hearing before ALJ had performed numerous vertebral artery surgeries during his career [Reporter's Transcript (hereinafter "Tr.") 2930-2934]. Petitioner is Board-certified as a Diplomate of American Board of Surgery [Exh. CCCCC] and American Board of Thoracic Surgery [Exh. CCCCC]. Petitioner is a Fellow of American College of Angiology [Exh. CCCCC], a founding member of Society for Neurovascular Surgery, and a member of Society of Thoracic Surgeons [Exh. CCCCC] and Western Thoracic Surgical Association, formerly called Samson Thoracic Surgical Society [Exh. CCCCC]. Prior to his hearing before ALJ, Petitioner had published

four articles on hindbrain ischemia, VBAI, and vertebral artery surgery in Surgery, Gynecology and Obstetrics [Exh. TT], in Vascular Surgery [Exh. SS] and in American Surgeon [Exh. NN]. [Tr. 2899-2904, 2928-2934]

Respondent, BMQA, controls licensing of medical doctors in California.

VI. STATEMENT OF FACTS AND PROCEEDINGS

This matter can be traced to a decision reached unilaterally by Earle J. Maile, MD, Medical Director of Blue Cross of Southern California (fiscal intermediary for Part A of Medicare Program), in September, 1976 concerning vertebral artery surgery to relieve hindbrain ischemia and VBAI:

> "On the basis of comments and recommendations from our surgical consultants, including specialists in the field of vascular surgery, we have determined that these procedures are investigational and not in accord with recognized standards of medical practice." [Exh. GGG (1); Tr. 2688-2689]

On September 22, 1976, Blue Cross of

Southern California unilaterally issued Medicare Bulletin No. 146:

> "All providers are hereby notified that vertebral artery surgery has been determined to be an investigiational procedure not in accord with recognized standards of medical practice. As such, it is excluded from Medicare program coverage." [Exh. GGG; Tr. 2688-2689]

Petitioner objected to Medicare Bulletin No. 146 and requested Dr. Maile to provide him with names of Blue Cross surgical consultants and their signed statements regarding vertebral artery surgery, but Dr. Maile refused to do so [Exh. GGG (2); Tr. 2689]. Subsequently Petitioner received a response to his questions about Blue Cross consultants in a letter dated January 23, 1977 from James B. Cardwell, Commissioner of Social Security:

> "It is my understanding that Blue Cross of Southern California has received no general statements about vertebral surgery from its consultants." [Exh.

GGG (7); Tr. 2692]

Petitioner received a letter dated September 20, 1976 from Dr. Maile of Blue Cross which stated:

> "It appears that referral to local peer review represents the most equitable means of resolving the question of whether or not the vertebral artery procedures described in the claims you have submitted to Medicare are in accord with community standards of medical practice. Arrangements are being made, therefore, to refer the matter to the Medical Services Review Committee of District 5 of the Los Angeles County Medical Association for peer review." [Exh. GGG (4); Tr. 2691]

Petitioner objected to Dr. Maile's referral of matter to Los Angeles County Medical Association (hereinafter "LACMA") District 5 of Santa Monica, since most of its members were on the staff of St. John's Hospital of Santa Monica [Tr. 2672-2688]. At that time, Petitioner was involved in

litigation with St. John's in a matter arising from its refusal over a ten-year period to grant Petitioner staff privileges allegedly because of Petitioner's Jewish religion [Los Angeles County Superior Court Complaint WEC 35476 is Exh. FFF; Exh. DDD and EEE; Tr. 2672-2688]. The matter was assigned over Petitioner's objections to an ad hoc committee of LACMA District 5 of Santa Monica. Five of the seven-member ad hoc committee (Plested, Gaal, Heric, Rich and Hodosh) were either employed by or on the staff at St. John's Hospital [Tr. 21, 218, 662-663, 1022, 1701, 2025]. Dr. Maile of Blue Cross submitted to the ad hoc committee parts of hospital charts of 22 Medicare, Medicare-Medicaid and Medicaid patients upon whom Petitioner had performed vertebral artery surgery. Petitioner was never afforded an opportunity to appear before the ad hoc committee although he unsuccessfully attempted to do so on one occasion after receiving an anonymous telephone call advising him that the committee would meet

that evening. When on January 17, 1977 Petitioner presented himself to the committee, two of the members (Plested and Gaal) told Petitioner that the committee would not meet if Petitioner insisted on being present [Exh. GGG (8); Tr. 2692-2698]. In March, 1977 the ad hoc committee reported to Dr. Maile of Blue Cross and to LACMA that vertebral artery surgery performed by Petitioner was not in accord with community standards of medical practice, and also lodged a complaint against Petitioner with BMQA regarding the 22 patients (who are also herein involved) and recommended that BMQA file charges against him [Tr. 2698]. As a result of this complaint against Petitioner from the ad hoc committee, BMQA issued an Accusation in October, 1978 against Petitioner. These same ad hoc Committee members became BMQA's witnesses at Petitioner's hearing before ALJ. There existed a conflict of interest with bias and prejudice on the part of five of BMQA's witnesses (Plested, Gaal, Heric, Rich and

Hodosh), since they were either employed by or on staff of St. John's Hospital [Tr. 21, 218, 662-663, 1022, 1701, 2025, 2673-2688, 2694-2696].

Petitioner submitted matter of whether vertebral artery surgery was "accepted medical practice" to California Medical Association (CMA) in October, 1976. CMA's Advisory Panel on General Surgery and Neurosurgery concluded on April 16, 1977 that vertebral artery surgery was "accepted medical practice" in selected cases of compressive disease demonstrated by angiography, including extralumenal lesions. [Exh. GGG (9); Tr. 2693, 2698-2699]

Petitioner sent Roger O. Egeberg, MD, Chief Medical Officer of Medicare, a copy of Medicare Bulletin No. 146 issued by Blue Cross and advised Dr. Egeberg that vertebral artery surgery was "accepted medical practice" throughout the world since the early 1960's, and that Dr. Maile and Blue Cross were totally wrong about vertebral artery surgery [Tr. 2690, 2699]. Petitioner

further advised Dr. Egeberg that a number of Medicare patients had died of fatal brainstem strokes because of their inability to have vertebral artery surgery (after suffering minor brainstem strokes) because of Medicare Bulletin No. 146 [Tr. 2699]. In April, 1978, Petitioner was advised by Dr. Roger Egeberg that he would be "pleased to learn" that Public Health Service had recommended that Medicare coverage be extended to various surgical procedures (including vertebral artery arteriolysis) to relieve obstructions to vertebral artery blood flow [Exh. GGG (10); Tr. 2699]. Thus, the general controversy over Medicare coverage for vertebral artery surgery was resolved in favor of Petitioner seven years ago.

On September 1, 1978 Medicare issued Transmittal No. 688(715), which states that vertebral artery surgery is reimburseable under Medicare Program [Exh. GGG (11); Tr. 2699]. Medicare Transmittal 688 does in particular three things of importance: it sets forth four conditions under which

vertebral artery surgery is considered reasonable and necessary, it designates the symptoms which are considered evidence of vertebral artery obstruction, and it designates the other causes which should be ruled out prior to surgery. Transmittal 688 states that vertebral artery surgery is medically reasonably and necessary if each of the following conditions is met: 1. Symptoms of vertebral artery exist; 2. Other causes have been considered and ruled out; 3. There is radiographic evidence of a valid vertebral artery obstruction; and 4. Contradictions to procedure do not exist.

BMQA's Accusation against Petitioner was the first of its kind - an Accusation that resulted from medical politics, resulting from a complaint from a group of doctors either employed by or on the staff of St. John's Hospital, Santa Monica, retaliating against Petitioner for his suit against St. John's Hospital [Exh. FFF; Tr. 2698]. None of the 22 patients named in the Accusation lodged a complaint with BMQA against

Petitioner; none of the 22 patients suffered any type of injury or complication as a result of vertebral artery surgery [Exh. 3A - 3V]. BMQA concluded in its Decision that there was "evidence of successful results in many of the 22 cases in question" [Jt.App. 113, lines 37-38].

On October 23, 1978 BMQA issued an Accusation [Jt. App. 1-39] charging Petitioner with "unprofessional conduct" under former B & P Code Section 2361, subdivision (b) gross negligence and subdivision (c) incompetence - now Sections 2234 b and d. Accusation alleged that in treatment of 22 patients, Petitioner was guilty of gross negligence in the following respects:

1. Failure to perform a complete history..

2. Failure to perform a complete physical examination.

3. Failure to develop a differential diagnosis.

4. Failure to have performed appropriate

neurological laboratory studies before subjecting patient to the angiogram or to surgery.

5. Failure to perform a neurological evaluation before subjecting patient to the angiogram or to surgery.

The Accusation further alleged that in the treatment of 22 patients, Petitioner was guilty of incompetence in the following respects:

1. History and physical do not justify diagnosis of hindbrain ischemia and vertebral artery surgery.

2. Aortic arch angiogram does not indicate a partial obstruction of proximal vertebral artery as evaluated by Petitioner.

Petitioner had a hearing before ALJ Cameron between November 13, 1980 and February 19, 1981, and ALJ's proposed decision was issued on June 3, 1981 which was adopted by BMQA. Applying the preponderance of evidence standard of proof, ALJ determined that Petitioner was guilty of gross negligence and incompetence and ordered his

Physician and Surgeon's certificate revoked. Relying upon the conclusion that "it would not be against the public interest to permit Dr. Hurvitz to practice medicine", the revocation was stayed and Petitioner was placed on probation for 5 years with the following conditions: 1. That Petitioner take educational courses on subject of hindbrain ischemia and vertebral artery surgery; 2. That Petitioner pass an oral examination on hindbrain ischemia and vertebral artery surgery; 3. That Petitioner "during the first two years of probation shall not perform any surgery on a vertebral artery unless he shall first obtain an opinion, in writing, concurring in the surgery, from another qualified Board-certified thoracic and cardiac surgeon" [Jt. App. 115].

The findings in BMQA's decision [Jt. App. 92-116] included the following: 1. Petitioner performed unjustified surgeries; 2. Petitioner failed to perform an adequate neurological evaluation; 3. The aortic arch angiogram does not indicate a significant

partial obstruction of the vertebral artery; 4. Petitioner was guilty of an omission in diagnostic procedures; 5. Petitioner was correct in his interpretation of the angiograms of five of the patients, Patients A, D, L, S and V; 6. Petitioner's opinions as to the commonest and importance of vertebral-basilar insufficiency find some support in other expert opinions.

Petitioner filed for a Writ of Mandamus on October 6, 1981 in Superior Court [Jt. App. 41]. On September 28, 1982, Superior Court Judge Savitch denied Petitioner's first petition for a writ of mandate. However, one week later, Judge Savitch vacated his order upon authority of Ettinger v. BMQA 135 Cal.App.2d 853, 856 (1982) because ALJ had not used the new standard of proof of clear and convincing evidence to a reasonable certainty. Judge Savitch ordered that "a writ of mandate issue directing the Respondent Board to reinstate the certificate here in issue until such time as it redetermines the cause" [Jt. App. 67]. BMQA

reinstated Petitioner's certificate to practice and then remanded case back to ALJ, who, after refusing to consider additional evidence, heard oral arguments and on January 5, 1984 issued a new proposed decision which was adopted by BMQA on February 15, 1984. The new decision adopted the earlier decision with the only significant modification being the statement that "conflicts have beem resolved by applying the standard of clear and convincing proof to a reasonable certainty" [Jt. App. 90].

An Amended Petition for Writ of Mandamus was filed on May 10, 1984 [Jt. App. 77]. Hearing on the Writ was scheduled for July 12, 1984 before Superior Court Judge Lawrence Waddington; when they appeared in court for the hearing Petitioner and his attorney were shocked to find Judge Savitch sitting in Judge Waddington's place. Judge Savitch denied the Writ and entered his judgment On August 7, 1984 [Jt. App. 195, 204-206].

Notice of Appeal was filed on September 11, 1984 [Jt. App. 208]. Court of Appeal

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filed its decision affirming judgment of Superior Court on May 13, 1985. Petition for Review by California Supreme Court was timely filed on June 19, 1985, and was denied on July 24, 1985.

VII. REASONS FOR GRANTING THE WRIT

A. There Was Violation Of Petitioner's Right Of Due Process Of Law By California Appellate Court's Decision Affirming Superior Court's Judgment Revoking Petitioner's License To Practice Medicine And Declaring Him Incompetent And Grossly Negligent Based On The Finding That Vertebral Artery Surgeries Performed By Him On 22 Patients Were Unnecessary And Inappropriate

Whether or not the 22 patients who had the vertebral artery surgery performed by Petitioner required the surgery must, of necessity, be a "scientific fact". Medical opinions vary. What one doctor may find necessary and appropriate, another doctor may find unnecessary and inappropriate. In our constitutional framework, we have laws that determine standards. Due process means that

before an individual may be penalized for his actions, he has a right to have a law exist which gives him notice of the prohibited conduct. Absence of such notice means a lack of due process of law.

There is no California State law setting forth the standards for the indications and performance of vertebral artery surgery. Petitioner was "tried and convicted" of violating a rule of law which does not exist. Medical opinions from BMQA or any doctor are not and cannot be laws. Legal rights cannot be adjudicated upon medical opinions.

B. California Appellate Court's Decision Affirming Superior Court's Judgment That Petitioner Was Guilty Of Incompetence And Gross Negligence And Revoking His Certificate To Practice Medicine And Thereby Depriving Petitioner Of A Valuable Property Right (his job and medical license) Clearly Violated Petitioner's Rights To Due Process Of Law Under First, Fifth and Fourteenth Amendments To US Constitution And Denied Him Judicial Review

Petitioner was entitled to judicial review of BMQA's decision. Petitioner's case failed to receive judicial review because the Superior Court Judge and Appellate Court Judges were incompetent to read and consider the 21 sets of angiographic xrays (390 xray films) which were the prime evidence. The Judges were not capable of understanding the subject matter and were not sufficiently knowledgeable to intelligently decide the case.

In his judgment denying peremptory writ of mandate [Jt. App. 205] which appears in the Appendix on page A7, SUPERIOR COURT JUDGE SAVITCH STATES THAT HE "read and considered sets of xrays pertaining to 21 patients". The Judge's legal incompetence to read and consider the xrays prevented the Superior Court from rendering its independent judgment on the underlying charges.

The 390 angiographic xrays [Exhibit (Exh.) 3BX through 3VX] pertaining to 21 patients were extremely important evidence. "Angiography is the mainstay in evaluating

cerebrovascular insufficiency" [Dye and Brown, Surgical Clinics of North America, Exh. XXX, p. 247]. "Angiography reveals the location of suspected vascular obstructions and eliminates other etiologic possibilities" [Toole and Patel, Cerebrovascular Disorders, Exh. AAAA, p. 148].

There were no markings on the 390 xrays, except on one film, resulting in an inadequate record violating the command in Franz v. BMQA , supra, and further prevented the Superior Court Judge from rendering his independent judgment on the underlying charges.

At Petitioner's hearing, ALJ read and considered all of the 390 angiographic xrays and gave his own interpretation of the xrays in his proposed decision, which he was incompetent to do. Petitioner was denied a fair hearing because the trier of fact (the ALJ) did not have the educational capability of comprehending the subject matter and lacked sufficient knowledge of complex medical matters to intelligently decide the

case.

C. California Business and Professions Code (B & P) Sections 2361 (b) And (c) As Applied To Particular Facts Of This Case Are Unconstitutionally Vague And Incapable Of Uniform Enforcement, Violating Petitioner's Constitutional Right Of Due Process And Equal Protection Of The Law, And Representing An Impermissable Delegation of Legislative Authority

B & P Sections 2361 (b) and (c) are in fact penal statutes by operation of B & P Section 2426. Because of the dual nature of the charged violations (unprofessional conduct and crimes), due process-criminal standards of certainty govern the constitutional examination of the validity of B & P Sections 2361 (b) and (c).

B & P Sections 2361 (b) and (c) have not been challenged for certainty in any case resulting in a published appellate decision.

These charging statutes are unconstitutional: They are wholly lacking in substantive content and are therefore

uncertain, and they may not be made reasonably certain by reference to other defineable sources; they deny equal protection under the law; they constitutute a delegation of legislative authority to BMQA and there are no safeguards adequate to prevent an abuse of this power.

Due process requires certainty in a statue which may impair a fundamental right. The right to practice medicine is such a valuable property right under the Constitution and laws of California. Hewitt v. Board of Medical Examiners 148 Cal. 590, 592 (1906). Acts or conduct which render the physician liable to penalty or forfeiture of his right to practice must be declared with such certainty and definiteness in the act that he may know exactly what they are. Id. The California Supreme Court stated: "Civil as well as criminal statutes must be sufficiently clear as to give a fair warning of the conduct prohibited, and they must provide a standard or guide against which conduct can be uniformly judged by courts and

administrative agencies." [Citations omitted.] Morrison v. State Board of Education 1 Cal.3d 214, 231, 82 Cal.Rptr. 175, 187 (1969). Accord : Wingfield v. Felder 29 Cal.App.3d 209, 105 Cal.Rptr. 619 (1973). The danger is that an unduly vague statute permits capricious or discriminatory application. Morrison , supra ; Grayned v. City of Rockford 408 US 104, 92 S.Ct. 2294 (1972).

It is a well-established constitutional rule that civil statutes must be written with clarity so that men of ordinary intelligence need not guess at their meaning. Connally v. General Construction Co. 269 US 385, 391 (1925). A person cannot be held to answer charges based upon penal statutes with mandates so uncertain that they will reasonably admit of different constructions; penal statutes prohibiting the doing of certain things and providing a punishment for their violation should not admit of such double meaning that the citizen may act upon the one conception of its requirement and the

courts upon another. United States v. Capital Traction Co. 34 App. D.C. 592, 598, language approved 269 US 385, 393 (1925). Exacting obedience to a rule so indefinite as really to be no rule at all, contravenes due process of law not only where obedience is exacted by imposing criminal penalties, but also where it is exacted by stripping a person of his rights under the law in a civil proceeding. A. B. Small Co. v. American Sugar Refining Co. 267 US 233, 239 (1924).

Regarding the equal protection requirement of certainty, Article IV, Section 16 of California Constitution requires that general laws be of uniform operation. It is generally considered that this State constitutional provision is the substantial equivalent of the Equal Protection Clause of Fourteenth Amendment to US Constitution. Serrano v. Priest 5 Cal.App.3d 584 (1971). Vagueness and ambiguity in statutory language cause B & P Sections 2361 (b) and (c) to run afoul not only of Due Process guarantees, but of the Equal Protection Clause as well.

California Supreme Court outlined how uncertain language prevents uniform operation of law. In re Newbern 53 Cal.2d 786, 797 (1960); Barker Bros. v. Los Angeles 10 Cal.2d 603, 609 (1938).

Where vagueness in a statute is not in issue, legislative compliance with equal protection mandates is analyzed in terms of relation between purpose of a statute and the distinctions between classes to which it differentially applies. Where the operative term of a statute is vague or ambiguous, it is difficult to apply this traditional equal protection analysis.

Strict scrutiny standard of equal protection applies in this case. Where statutes involve certain "suspect classifications" or impinge on "fundamental interests" the court must adopt an attitude of active and critical analysis, subjecting the classification to "strict scrutiny". Serrano v. Priest 5 Cal.3d 584, 597 ((1971). The right to practice medicine is such a fundamental interest. Hewitt , supra ; Anton

v. San Antonia Community Hospital 19 Cal.3d 802, 140 Cal.Rptr. 442 (1977).

B & P Sections 2361 (b) and (c) must be held void for uncertainty unless relevant terms may be made reasonbly certain by reference to other definable sources. County of Nevada v. MacMillen 11 Cal.3d 662,673 114 Ca.Rptr. 345 (1974); Frank v. Municipal Court 145 Cal.App.3d 200, 193 Cal.Rptr. 299, 301 (1983). Courts applying this principal have found "other definable sources" in federal or other state laws, Frank , supra, or "common experiences of mankind", MacMillen , supra, 11 Cal.3d at 673, 114 Cal.Rptr, at 351 (quoting People v. Daniels 71 Cal.2d 1969). In this latter category must be grouped cases which defined "unprofessional conduct" under circumstances involving charges of moral turpitude only. See, e.g., Morrison , supra; Shea v. Board of Medical Examiners 81 Cal.App.3d 564, 146 Cal.Rptr. 653 (1978). This case, however, presents a problem which cannot be solved by reference to another law or by looking merely to common experience:

there is no definition of "incompetence", "gross negligence", "ordinary standard of conduct", or "extreme departure from ordinary standard of conduct". It is the lack of certainty in the standards which renders the statutes vague.

GROSS NEGLIGENCE

State of California Business and Professions Code does not define "gross negligence". The term "gross negligence" as used in subsection (b) of Section 2361 was first judicially construed in decision of Gore v. BMQA 110 Cal.App.3d 184, 167 Cal.Rptr. 881 (1980). In its discussion, the court adopted the definition of "gross negligence" used by California Supreme Court in Van Meter v. Bent Construction Co. 46 Cal.2d 588, 594 (1956), "the want of even scant care or extreme departure from the ordinary standard of conduct", but did not consider whether so construed the statute met the constitutional requirement of certainty and did not discuss how the standard of conduct should be established. The

subsequent decision in Franz v. BMQA , supra, 31 Cal.3d at 124 (1982) declared that the pertinent medical standard for "gross negligence" must be supplied by expert testimony on the record. The difficulty is that the procedure approved in Franz fails to satisfy all of the requirements of due process. As Morrison , supra, makes clear, the constitution mandates that all statutes "provide a standard or guide against which conduct can be uniformly judged by courts and administrative agencies." By permitting the "ordinary standard of conduct" and what represents the "extreme departure from the ordinary standard of conduct" to be left in the hands of various doctors who happen to testify at a particular hearing, the Franz decision allows a standard which is vague, amorphous and constantly changing; as a practical matter, it establishes no standard at all and certainly not one that can be uniformly applied.

This problem is exacerbated by the fact that the administrative record must be

reviewed independently by a judge untrained in medical matters. It is one thing for a lay judge to determine, as a factual matter, that a particular act deviates extremely from an accepted norm, but it is quite another for a lay judge to ascertain what the appropriate standard should be in the first place.

In civil tort context, the concept labeled "negligence" is distilled into component parts: a standard of conduct, an act or omission violating that standard and proximately causing "damage". The standard of conduct is further refined in its application to medical negligence - a standard of conduct, an act or omission violating that standard and causing "bodily injury". It is reasonable to assume that the California legislators intended the term to be used in that usual legal context. A tort system has as its rationale, compensation to individuals, and incidental cost allocation, for damage or injury. None of the patients herein involved suffered any bodily injury or

artery surgery performed by Petitioner, and therefore Petitioner is not and cannot be guilty of any gross negligence.

A statute must give fair warning of the conduct prohibited and provide a standard capable of uniform application. Section 2361 (b) fails to establish an ordinary standard of conduct and it violates the Constitution to have that standard, as well as what represents an extreme departure from that standard, supplied by "expert" testimony only at the time of the hearing. Accordingly, Section 2361 (b) does not satisfy due process and must, therefore, be declared unconstitutional.

INCOMPETENCE

The meaning of "incompetence" as used in B & P Section 2361 (c) has not been directly considered by a court. Pollack v. Kinder 85 Cal.App.3d 833, 837 (1978) considered the interpretation of the term "incompetence" as found in Section 1668 of the Insurance Code. Citing People v. Curtis 70 Cal.2d 347, 355 (1969), the court concluded that incompetence

and negligence were not synonymous, that incompetence denoted a demonstrated inability to perform general duties and functions of a licensee. The court in Pollack simply defined the statutory term "incompetency" and did not test it against the constitutional requirement for certainty. The court in fact acknowledged that the technical term "incompetency" is a relative one generally used in a variety of factual contexts to indicate an absence of qualification, ability or fitness to perform a prescribed duty or function.

Applicability of the Pollack definition of incompetence to the State of California Medical Practice Act is not clear. The "general duties and functions" of an insurance licensee can be said to differ in scope from that of a physician. In fact the difference in scope is of such magnitude that there is substantially less certainty in the phrase "demonstrated inability to perform the general duties and functions" of a physician than in the standard defined in Pollack

relating to insurance licensees. Also it appears that the constitutional requirement for a clear and certain statute is greater where a physician's license is the subject of the statute, since no cases appear to have held that like a physician's right to practice, an insurance agent's license is a valuable property right or that the Insurance Code is subject to a strict scrutiny standard of review in its disciplinary provisions.

With the Pollack "standard" applied to physicians, the vice lies in the inability of a board, or a court reviewing a board's decision, to say what the "general duties and functions" of a physician are. Even if that problem could be overcome, a court or board would have to discern whether it is the inability to perform any of those general duties or functions or an inability to perform only certain of the general duties and functions that constitute incompetency.

B & P Code Section 2361 (c) reveals a degree of uncertainty that is unnecessary and inappropriate; it does not satisfy due

process; it subjects physicians to a disciplinary standard which cannot be uniformly applied; it must be declared unconstitutional.

DELEGATION OF LEGISLATIVE AUTHORITY

The purpose of the doctrine prohibiting the delegation of legislative power is to assure that "truly fundamental issues [will] be resolved by the Legislature and that a grant of authority [is]...accompanied by safeguards adequate to prevent its abuse." Wilke & Holzheiser, Inc. v. Dept. of Alcoholic Beverage Control 65 Cal.2d 349, 369, 55 Cal.Rptr. 23, 36 (1966). Accord : Kugler v. Yocum 69 Cal.2d371, 71 Cal.Rptr. 687 (1968). B & P Sections 2361 (b) and (c) are valid only if they include safeguards adequate to prevent an abuse of the authority delegated to BMQA to determine and punish acts of unprofessional conduct. Bayside Timber Co. v. Board of Supervisors of San Mateo County 20 Cal.App.3d 1, 97 Cal.Rptr. 431 (1971).

There are no ascertainable standards to

guide the decisionmaker and lack of defineable standards precludes adequate safeguards. There is simply no way for a lay judge to determine whether the ordinary standard of conduct adopted is the correct one and whether the allegation of extreme departure from the ordinary standard of conduct is correct, no way to determine if a physician demonstrates inability to perform the general duties and functions of a licensee, and therefore, the determination of those issues by BMQA evades effective review.

The right to practice medicine is fundamental. Hewitt , supra ; Anton , supra. Delegation of legislative authority to BMQA is unconstitutional because B & P 2361 (b) and (c) establish no specific standards and, more importantly, contain no safeguards adequate to prevent an abuse of power. The California Legislature cannot constitutionally avoid its responsibility as to such fundamental issues "by explicitly delegating that function to others or by failing to establish an effective mechanism

to assure the proper implementation of its policy decisions." Bayside Timber Co ., supra 20 Cal.App.3d at 11, 97 Cal.Rptr. at 437 (quoting Kugler). Accordingly, Sections 2361 (b) and (c) should be declared unconstitutional.

D. Petitioner's Published And Non-published Ideas Of Medical Research Regarding Diagnosis Of Hindbrain Ischemia And Surgical Treatment Of Symptomatic Hindbrain Ischemia With Vertebral Artery Surgery Are Protected By The Freedom Of Speech Clause In First Amendment To US Constitution And His Rights To Freedom Of Speech Were Violated By California Appellate Court, Superior Court And BMQA When They Declared Petitioner Incompetent And Revoked His Medical License

Appellate Court, Superior Court and BMQA abridged Petitioner's freedom of speech by declaring him incompetent and by revoking his license to practice medicine. Prior to his hearing before ALJ, Petitioner had published four articles on hindbrain ischemia, VBAI and vertebral artery surgery in three different

surgical journals [Exh. TT, SS, NN; Tr. 2899-2904, 2928-2934]. Petitioner was and is an expert in the diagnosis and surgical treatment of hindbrain ischemia, and as of date of hearing before ALJ had performed numerous vertebral artery surgeries during his career [Tr. 2930-2934].

E. Petitioner Was Denied Adequate Notice Under Due Process Clauses Of Fifth And Fourteenth Amendments To US Constitution Of The Precise And Specific Charges Against Him With Loss Of First Amendment Freedoms -- Under Fifth And Fourteenth Amendments, ALJ Was Barred From Bringing New Charges Against Petitioner And Also Proposed Decision Of ALJ Which Was Adopted By BMQA Must Be Limited In Its Adverse Findings (Charges) To The Precise Charges Alleged Against Petitioner By BMQA In Its Accusation

BMQA's Accusation [Jt. App. 1-39; see above, pages 20-21] charged Petitioner with failure to perform A neurological evaluation - in its adopted decision, BMQA found that he failed to perform an ADEQUATE neurological

evaluation. BMQA's Accusation charged that aortic arch angiograms do not indicate a partial obstruction of proximal vertebral artery - in its decision, BMQA found that angiograms do not indicate a SIGNIFICANT partial obstruction of vertebral artery in 16 patients. BMQA found in its decision that Petitioner omitted diagnostic procedures - there was no such charge in Accusation.

In Eisenberg v. Mathews 420 F.Supp. 1274, 1281 (D.C. Pa. 1976), the court stated: "Prior to the hearing, should it be scheduled, the plaintiffs shall be informed of the precise charges against them and shall be given a reasonable opportunity to respond to each at the hearing."

Under the Fifth and Fourteenth Amendments, procedural due process protections apply when there has been interference with a property right, such as a medical license. Hathaway v. Mathews 546 F.2d 227 (7th Cir. 1976); Ivy Nursing Home v. Califano W.D.Pa. Civ.No.77577 585 (1977). Such property interests warrant full due

process safeguards. Goss v. Lopez 419 US 565 (1975); Goldberg v. Kelley 397 US 254 (1970). This Court has instructed that in such cases, compliance with the requirements of due process must be tested by a balancing of, (1) the private interest and risk of deprivation of that interest, against (2) the apparent government interest. Mathews v. Eldridge 44 US 319 (1976); Memphis Light, Gas and Water Division v. Craft 436 US 1, 98 S.Ct. 1554 (1978).

Having gone through the hearing before ALJ without receiving Notice in advance of all of the precise and specific charges against him, Petitioner was denied his right to a fair hearing. This, in itself, constitutes irreparable harm -- loss of Petitioner's Constitutional right to fair treatment by California State Government. "The loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury." Elrod v. Burns 427 US 347, 96 S.Ct. 2673, 2689-2690 (1976); cf., New York Times Co. v. US 403 US

713, 91 S.Ct. 2140 (1971); Cate v. Oldham 707 F.2d 1176, 1185-1190 (11th Cir. 1983); American Broadcasting Co. Inc. v. Cuomo 570 F.2d 1080, 1084 (2nd Cir. 1977); A Quaker Action Group v. Hickel 421 F.2d 1111, 1116 (D.C. Cir. 1969). The rule that invasion of a constitutional protected right is, itself, irreparable injury is not limited to First Amendment rights, but extends to Due Process Rights like those raised herein. United Church, Etc. v. Medical Center Com'n 689 F.2d 693, 700-701 (7th Cir. 1982); Planned Parenthood v. Citizens For Com. Action 558 F.2d 861, 867 (8th Cir. 1977).

Courts of this land have been consistent in their enforcement of constitutional requirement that adequate notice be given when a protected property interest is at stake. Rationale for this strict requirement is rooted in practical need for information. As this Court stated, "The purpose of notice under the Due Process clause is to apprise the affected individual of and permit adequate preparation for an impending

hearing." Memphis Light, Gas and Water Division v. Craft , supra ;cf., Wolf v. McDonnell 418 US 539, 564 (1974); Morrisey v.Brewer 408 US 471, 486-487 (1972); In re Gault 387 US 1, 33 (1967); Anti-Fascist Comm. v. McGrath 341 US 123, 171-172 (1951); Federal Trade Comm. v. Carter 636 F.2d 781, 791 (D.C.Cir. 1980).

F. There Was Violation Of Petitioner's Right Of Due Process And Denial To Petitioner Of His Constitutional Right To A Fair Hearing Before ALJ

Petitioner was denied his right to a fair hearing before ALJ - five of BMQA's witnesses (Plested, Gaal, Heric, Rich and Hodosh) had a conflict of interest with bias and prejudice, since they were employed by or on the staff of St. John's Hospital, Santa Monica. As described above on pages 14-15, Petitioner was involved in litigation with St. John's.

Petitioner was denied his right to a fair hearing before ALJ, since BMQA's witnesses were not competent regarding

hindbrain ischemia and vertebral artery surgery [see below, page 61]. Petitioner's attorney objected to appearance of BMQA's non-expert witnesses and made motions that they be dismissed as witnesses, that they not be permitted to testify, and that their testimony be stricken from the record; ALJ overruled these motions [Tr. 222, 223, 672-673].

ALJ was not competent to read, consider and interpret the 390 angiographic xrays in his proposed decision. ALJ did not have the educational capability of understanding the subject matter and was not sufficiently knowledgeable of complex medical matters to intelligently decide the case.

G. BMQA's Decision Revoking Petitioner's Certificate To Practice Medicine Was Illegal And Irrational Since Decision States That "It Would Not Be Against The Public Interest To Permit Dr. Hurvitz To Practice Medicine" And That Petitioner Is A "Qualified Board-certified Thoracic And Cardiac Surgeon" And Nowhere In Decision Does It Indicate That

Petitoner Is Unfit To Practice Medicine

The Court in Shea v. Board of Med. Exam., supra, 564, 574-575, states that "unprofessional conduct" must encompass conduct which indicates an unfitness to practice medicine. BMQA's decision states that "it would not be against the public interest to permit Dr. Hurvitz to practice medicine" [Jt.App.114, lines 26-28], and describes Petitioner as a "qualified Board-certified thoracic and cardiac surgeon" [Jt.App.115, lines 43-44].

H. There Was No Incompetence On The Part Of Petitioner In Treatment Of The Twenty-two Patients, Since Irrefutable Evidence Of Significant Partial Obstruction Of The Operated Vertebral Artery Was Found At Surgical Operation In Each Patients And Was Recorded In The Operative Reports And Was Corroborated By Testimony Of Assistant Surgeon

Petitioner's witness Adam Wesolowski (Wesolow) testified that "actually the diagnosis is made at operation and not by the

pathologist" [Tr. 1350]. Each of the 22 patients named in the Accusation had diagnosis of hindbrain ischemia and VBAI proven at time of surgery; Petitioner clearly recorded the abnormal, significant findings of extralumenal partial obstruction of vertebral artery on the progress sheet of hospital chart and in the typed and signed Operative Report in the hospital chart, under heading "Operative Findings" [Exh. 3A through 3V; Jt. App. 119-164].

In each of the 22 patients, Petitioner recorded on progress sheet of hospital chart and in the typed and signed Operative Report a description of his surgical correction of partial vertebral artery obstruction [Exh. 3A-3V].

P. H. Steller, MD, who assisted Petitioner with vertebral artery surgery on 17 patients, gave testimony corroborating and verifying the recorded operative findings of partial vertebral artery obstruction and the recorded surgical correction by Petitioner of vertebral artery obstruction in 17 patients

[Tr. volume 17, 2199-2313; Jt. App. 119-164].

BMQA witness Heric testified that Petitioner's "word and his described findings at surgery must be accepted as true" [Tr. 446].

I. There Was No Gross Negligence On The Part Of Petitioner In Treatment Of The Twenty-two Patients, Since No Patient Suffered Any Bodily Injury Or Complication As A Result Of Surgery And There Was A Stipulation That The National Ordinary Standard Of Conduct Applied In Petitioner's Case

None of the 22 patients suffered any type of bodily injury or complication as a result of vertebral artery surgery [Exh. 3A through 3V]. All 22 patients had immediate objective post-operative improvement after vertebral artery surgery, which was recorded in their hospital charts by their private physicians and by Petitioner [Exh 3A-3V; Jt. App. 119-164]. BMQA concluded in its adopted decision that there was "evidence of successful results in many of the 22 cases in

question" [Jt.App.113, lines 37-38].

BMQA's attorney and Petitioner's attorney stipulated during hearing before ALJ that regarding charge of gross negligence, that the national ordinary standard of conduct applied in Petitioner's case [Tr. 385, 1372-1373, 1379]. These national standards of conduct were presented in testimony by Petitioner's witnesses, Drs. Wesolowski, Woods and Bonecutter. The standard of conduct allegedly used by BMQA's non-expert witnesses at St. John's Hospital did not apply in this case.

The 22 hospital charts of the patients, Exhibits 3A through 3V, are clear proof that Petitioner performed within the national ordinary standard of conduct. A "Patient Summary" for each patient was prepared from each of the 22 hospital charts, from Reporter's Transcripts, and from Exhibits; these 22 Patient Summaries are found in the Joint Appendix submitted to Appellate Court on pages 119-164.

There was a violation of Petitioner's

Constitutional right to due process and an abuse of discretion in that ALJ failed to apply the national standard of conduct that was stipulated to by both sides. There was a violation of Petitioner's right to due process and an abuse of discretion in that ALJ established his own standard for the indications and performance of vertebral artery surgery, and his own standard of conduct in deciding what constituted a complete history, what constituted a complete physical examination, what constituted an adequate neurological evaluation, what constituted an omission in diagnostic procedures, and what xray findings constituted a significant partial obstruction of the vertebral artery on angiographic xrays.

BMQA witness Plested testified that Petitioner performed a "proper screening neurological examination" on all patients [Tr. 250-251]. BMQA Heric testifed that as a Consultant Petitioner was NOT required to perform a complete physical examination, and

was not required to develop a differential diagnosis [Tr. 2525].

Four patients gave testimony to their excellent long-term objective improvement, lasting over 5 years - Patient H, Toomey [Tr. 2381-2384; Jt. App. 134]; Patient Q, Soliz [Tr. 2393-2403; Jt. App. 154]; Patient U, Pickens [Tr. 2030-2038; Jt. App. 161-162]; Patient V, Tanner [Tr. 2416-2418; Jt. App. 164].

Three private physicians testified regarding the extensive pre-operative medical work-ups their patients underwent and also regarding the good long-term objective post-operative improvement of their patients after vertebral artery surgery: 1. Lester H. Gross, MD - Patient H, Toomey [Tr. 2327, 2335-2337; Jt. App. 134]. 2. Bernard S.Pearson, MD - Patient Q, Soliz [Tr. 2374-2379; Jt. App. 153-154]. 3. P. H. Steller, MD - Patient B, Wayne [Tr. 2259-2260; Jt. App. 122]; Patient E, Cole [Tr. 2267; Jt. App. 128]; Patient G, Dobiers [Tr. 2210-2212; Jt. App. 132]; Patient N,

Poage [Tr. 2223; Jt. App. 146]; Patient S, La Jeunesse [Tr. 2239-2240; Jt. App. 157]; Patient V, Tanner [Tr. 2245-2246, 2248-2250, 2253; Jt. App. 163-164].

J. Congress Intended That The Treating Physician Should Determine What Services A Patient Requires And The Named Twenty-two Patients Exercised Their Constitutional Right By Electing To Have Vertebral Artery Surgery

In Breeden v. Weinberger 377 F.Supp. 734 (D.C. La. 1974), the court stated: "Under Medicare provisions, Congress intended that the responsibility for determining what services a patient requires is to rest primarily with the treating physician, and that the physician's decision is to be given great weight."

In Rowe v. Norton 380 F.Supp. 725-726, 729 (D.C. Conn. 1974), the court stated: "When a patient's condition does require some medical attentiion, the choice of service to be rendered should normally be a matter between doctor and patient,...once Government decides to provide payments, it must not

unduly disadvantage those who exercise a constitutional right by withholding payments for exercise of the right."

In Pippin v. Richardson 349 F.Supp. 1365, 1369-1370 (D.C. Fla. 1972), the court stated: "The Medicare Act which creates health insurance for the aged is remedial and therefore to be construed liberally to effectuate the congressional purpose of insuring that adequate medical care is available to the aged throughout the country."

K. All Charges In BMQA's Accusation Are False As Shown By Testimony Of Petitioner's Expert Witnesses

The charges in Accusation are listed above, on pages 21 and 22. By reviewing Exhibits 3A through 3V, the hospital charts of the 22 patients, one can readily appreciate that all charges in Accusation are irrational and unfounded.

Petitioner's witnesses Wesolowski [Tr. volumes 11 and 12, 1285-1626], Woods [Tr. 1630-1632, 1637; Exh. UU], and Bonecutter

[Tr. 2569-2726] testified that they reviewed all medical records of the 22 patients and that each hospital chart contains an adequate history, an adequate physical examination, evidence that other causes were considered and ruled out (differential diagnosis), evidence of appropriate neurological laboratory studies before angiography, an adequate neurological evaluation, a history and physical examination with recorded symptoms and signs justifying the diagnosis of hindbrain ischemia and vertebral artery surgery, and recorded findings of partial obstruction in angiograms of the operated vertebral artery - and that vertebral artery surgery on all 22 patients was warranted, justified and appropriate.

Petitioner's witnesses Wesolowski [Tr. 1624], Woods [Tr. 1630-1632, 1637; Exh. UU; Jt. App. 165-168], and Bonecutter [Tr. 2569-2726] testified that no charge or allegation against Petitioner in Accusation of incompetence or gross negligence is true.

Petitioner's witness Wesolowski testified that he reviewed all 21 sets of angiographic xrays, totalling 390 xray films, and that he found significant partial obstruction in angiograms of the operated vertebral artery in all 21 patients. Xrays of Patient A, Wilson, are not in evidence. Dr. Wesolowski's testimony on the 21 sets of xrays is found in "Patient Summaries" in Joint Appendix on pages 122 -163.

Petitioner's witness Burrows, a Board certified Radiologist, testified on his written reports of 16 sets of angiographic xrays of 16 of the named patients, and he testified that all his reports contain descriptions of significant abnormalities of partial obstruction of the operated vertebral arteries [Tr. 2863-3020; Jt. App. 122-164].

Wiley Barker, MD, Professor of Surgery, UCLA School of Medicine, regards Petitioner's witness Wesolowski as "a pioneer in the field of vascular surgery" [Exh. N]. Dr. Wesolowski published 165 articles and textbooks, including two leading articles on

subject of hindbrain ischemia and vertebral artery surgery. He is Board-certified as a General, Thoracic and Cardiovascular Surgeon, and his Curriculum Vitae unquestionably establishes him as a leading expert in the field of hindbrain ischemia and vertebral artery surgery [Jt. App. 169-189]. As of hearing date, Dr. Wesolowski had performed over 200 vertebral artery surgeries [Tr. 1289], and in his publications described operations on 140 patients [Tr. 1321; Exh. A and MM]. He testified that since 1965 "I did over 150 aortic arch angiograms myself and I eventually trained certain radiologists in the technique also teaching them how to interpret vertebral artery angiography" [Tr. 1295].

Petitioner's witness Woods practices Neurosurgery in San Diego, California. He is Board-certified by American Board of Neurosurgery, and in Neurology by American Board of Pschiatry and Neurology; he is a member of American Academy of Neurology and of American Association of Neurological

Surgery [Exh.YY, UU]. Dr. Woods published 21 articles, three on treatment of hindbrain ischemia [Exh. UU]. Dr. Woods testified: "I have performed approximately one thousand cervico-brachial neurovascular decompression operations, all of which involved an extralumenal vertebral artery decompresson" [Tr. 1630].

L. BMQA's Witnesses Were Not Competent Regarding Hindbrain Ischemia And Vertebral Artery Surgery

BMQA's witnesses demonstrated a startling lack of competence, knowledge and expertise regarding hindbrain ischemia and vertebral artery surgery:

1. Dr. William Plested (opined as to eight cases).

"Q. [By Petitioner's Attorney]: Dr. Plested, you are a surgeon. Have you ever done surgery on a vertebral artery?

"A. [By Plested]: No, I haven't.

"Q. Have you ever been present when surgery has been done on the vertebral

artery?

"A. [By Plested]: No, I haven't.

"Q. Can you tell us today what the signs and symptoms of vertebral basilar artery insufficiency are?

"A. [By Plested]: No, I can't. That's clearly not in the realm of expertise of a vascular surgeon." [Tr. 220-221]

2. Dr. Peter Gaal (opined as to seven cases).

"Q. [By Petitioner's Attorney]: Have you ever done a procedure, an operation, on the vertebral artery?

"A. [By Gaal]: No.

"Q. Have you ever seen a surgical operation done on the vertebral artery?

"A. [By Gaal]: No.

"Q. You do not consider yourself, therefore, an expert on vertebral artery surgery?

"A. [By Gaal]: That's true."

[Tr. 666-668]

3. Dr. Thomas Heric (opined as to 22

cases.

"Q. [By Petitioner's Attorney]: I think we both agree that the opinion of Dr. Wesolowski is -- from his history and background, education, training, publications, is certainly one that should be considered as competent. Would you agree with that?

"A. [By Heric]: No, I don't necessarily agree with that, because I've not really reviewed Dr. Wesolowski's background, training, et cetera. And my reading of his work has been very cursory, and I don't hold myself out to be an expert in the area of extralumenal surgery of the vertebral artery." [Tr. 1780]

4. Dr. J. Ronald Rich (opined as to eight cases).

"Q. [By Petitioner's Attorney]: Now, Doctor, I know you are here and you are an expert neurosurgeon. Let me ask you questions regarding your expertise. Are you here as an expert

who has devoted much of your time or any of your time to a study of the vertebral artery?

"A. [By Rich]: No.

"Q. [By BMQA's Attorney]: Dr. Rich, on cross-examination you testified that you had not personally ever operated on the proximal vertebral artery. I take it that that isn't part of your specialty?

"A. [By Rich]: That's correct."

[Tr. 156, 1918-1920, 1923]

M. Petitioner Recorded Pre-operatively In Hospital Charts Of Each Patient Xray Evidence Of Partial Obstruction Of Vertebral Artery [Exh. 3A-3V]

Petitioner's reliance on his own interpretation of angiographic xrays was reasonable and is the accepted local and nation-wide standard of practice of Vascular Surgeons as testified to by Adam Wesolowski, MD [Tr. 1598] and as shown by letter from Robert Katz, MD, a Vascular Surgeon in Los Angeles [Exh. XXXX].

N. Appellate Court's Decision Disregarded The Overwhelming Weight Of Evidence, And There Were Prejudicial Abuses Of Discretion On The Part Of Appellate Court, Superior Court, BMQA And ALJ

VIII. CONCLUSION

For these reasons, a writ of certiorari should issue to review the judgment and opinion of California Court of Appeal.

If writ of certiorari is granted, then Petitioner requests that this Court reverse Appellate Court's judgment, nullify disciplinary action, order that this matter be dismissed and that BMQA reinstate Petitioner's certificate to practice.

Respectfully submitted,

October 14, 1985 S Allan Hurvitz

S. ALLAN HURVITZ, MD
2080 Century Park East
Suite 508
Los Angeles, CA 90067
Tel.: (213) 477-5575
Petitioner, In Pro Se

APPENDIX

CALIFORNIA SUPREME COURT'S

NOTIFICATION OF DENIAL OF

PETITION OR REVIEW

CLERK'S OFFICE, SUPREME COURT
4250 STATE BUILDING

SAN FRANCISCO, CALIFORNIA 94102

JUL 24 1985

I have this day filed Order

REVIEW DENIED

In re: *No.* B007663

SEYMOUR ALLAN HURVITZ, MD,

vs.

DIVISION OF MEDICAL QUALITY

Respectfully,

Clerk

BEST AVAILABLE COPY

SUPERIOR COURT'S JUDGMENT

DENYING PEREMPTORY WRIT OF MANDATE

A4

JOHN K. VAN DE KAMP, Attorney General
of the State of California
M. GAYLE ASKREN, Deputy Attorney General
110 West A Street, Suite 700
San Diego, California 92101
Telephone: (619) 237-7989
Attorneys for Respondent

SUPERIOR COURT OF THE STATE OF CALIFORNIA
FOR THE COUNTY OF LOS ANGELES

SEYMOUR ALLAN HURVITZ, M.D.,

Petitioner,

v.

DIVISION OF MEDICAL QUALITY,
BOARD OF MEDICAL QUALITY ASSURANCE,
STATE OF CALIFORNIA,

Respondent.

No. C 384882

JUDGMENT DENYING PEREMPTORY WRIT
OF MANDATE

(JULY 12, 1984 9:00 a.m.
Department 86)

FILED: August 7, 1984

The above-entitled matter having come regularly on for hearing on July 12, 1984, at the courtroom of Department 86 of the above-entitled court, located at 111 North Hill Street, Los Angeles, California, before the Honorable Leon Savitch;

Petitioner appearing by his counsel, who were Glassman and Browning, and David R. Hinden., of the firm; and respondent appearing by its counsel, John K. Van de Kamp, Attorney General of the State of California, by M. Gayle Askren, Deputy Atttorney General; and

The entire administrative record which is the subject matter of the within proceedings, consisting of the complete reporter's transcript of the administrative hearing in 25 volumes, eleven complete and

separate volumes of exhibits, and sets of X-rays pertaining to 21 patients, all of which have been filed with this court, and the same having been read and considered by the court; and

The petition for writ of mandate and exhibits attached thereto having been filed with this court, and the same having been read and considered by the court; and

The court having read all the papers on file in the action, and the matter having been orally argued and submitted and the court having been fully advised in the premises; and

The court having found that respondent has afforded petitioner a fair trial and that there was no prejudicial abuse of discretion; and

The court having exercised its independent judgment on the evidence and having determined that the findings of respondent Division of Medical Quality of the Board of Medical Quality Assurance are supported by the weight of the evidence, and

its decision is supported by the findings:

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED:

That the alternative writ of mandate heretofore issued herein is hereby discharged;

That a peremptory writ of mandate is denied to petitioner;

That petitioner shall take nothing by his action; and

That parties shall bear their respective costs.

DATED: August 7, 1984

/s/ Leon Savitch

LEON SAVITCH

Judge of the Superior Court

JUDGMENT AND OPINION OF CALIFORNIA

APPELLATE COURT

A9

NOT TO BE PUBLISHED

IN THE COURT OF APPEAL

OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION FIVE

SEYMOUR ALLAN HURVITZ, M.D.,

Petitioner and Appellant,

v.

DIVISION OF MEDICAL QUALITY, et al.,

Respondent.

B007663

(Super. Ct. No. C384882)

FILED: May 13, 1985

Seymour Allan Hurvitz, M.D. (appellant) appeals from a trail court judgment denying a peremptory writ of mandate against the Board of Medical Quality Assurance (Board). The Board stayed revocation of appellant's license and placed him on five years probation after an administrative law judge

(ALJ) found him culpable of gross negligence and incompetence regarding twenty-two patients.

Appellant contends that the trail court failed to make an independent judgment on the underlying charges and impermissibly required him to prove that the Board's decision was contrary to the weight of the evidence. Appellant also contends that insufficient evidence existed to support the trail court's decision and that the charging statute was unconstitutional.

BACKGROUND

In 1978 the Division of Medical Quality of the Board filed an Accusation against appellant in connection with surgeries he had performed on 22 patients to relieve a condition he diagnosed as hindbrain ischemia. Between November 13, 1980, and February 19, 1981, evidence as to the accuracy of appellant's diagnoses and the appropriateness of his treatment was heard by an ALJ. On June 3, 1981, based on a preponderance of the evidence standard of proof, the ALJ issued a

proposed decision, later adopted as the decison of the Board, which made detailed findings that appellant had been grossly negligent and incompetent as to each of the 22 patients. The ALJ also made general findings that appellant's diagnostic proceedings and diagnoses represented an extreme departure from accepted medical practice, that his angiographic (vascular X-ray) interpretations were frequently erroneous and that his surgeries were unjustified.

As to each cause for discipline delineated in the ALJ's Determination of Issues, appellant's physician's and surgeon's certificate was revoked. Execution of the revocation was stayed pending completion of five year's probation. The principal terms of probation were that appellant complete a clinical education program in a subject area related to the violations stated in the ALJ's decision, that he pass an oral examination administered by the Board after completion of the clinical program, and that he not perform

surgery on a vertebral artery during the first two years of probation without first obtaining a concurring opinion from a qualified surgeon.

On September 28, 1982, the court denied appellant's first petition for an administrative writ of mandate, concluding that in its independent judgment, the findings of the Board were supported by the weight of the evidence. One week later, the court vacated its order in light of the new standard of proof for license review enunciated in Ettinger v. Board of Medical Quality Assurance (1982) 135 Cal.App.3d 853, 856. The court remanded the matter to the Board for application of the more stringent standard established in Ettinger -- that of clear and convincing proof to a reasonable certainty.1/

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1. Prior to Ettinger, "preponderance of the evidence" was used as the standard of proof in administrative hearings to revoke or suspend a doctor's license.

On January 12, 1983, the Board reinstated appellant's certificate to practice and ordered the case be remanded to the ALJ for redetermination in accord with the standard of proof enunciated in Ettinger. On January 4, 1984, the ALJ issued a proposed decision which ordered revocation of appellant's license and stayed the revocation subject to certain terms of probation. The Board adopted the proposed decision and denied appellant's petition for reconsideration.

On August 7, 1984, the trial court denied appellant's second petition for peremptory writ of mandate. The court stated that it had considered the reporter's transcript of the administrative hearing which consisted of 25 volumes of testimony, 11 volumes of exhibits and the xrays of 21 patients and concluded that appellant had been afforded a fair trial and that the Board's decision was supported by the weight of the evidence.

DISCUSSION

I

The Board introduced into evidence 21 separate sets of angiographic X-rays, composed of 390 separate X-ray films. Appellant argues that witnesses often testified without identifying the specific films to which they referred and that featured aspects of the X-rays were often left unmarked. Appellant contends that failure to mark the radiographic evidence with specificity resulted in an inadequate record and prevented the trial court from making an independent judgment on the underlying charges. He further charges that any such deficiencies constitute a jurisdictional defect which allows appellant to raise this issue for the first time on appeal. We disagree.

We find nothing in the record which shows that appellant heretofore complained about the identification and preservation of the angiographic X-rays. A party may not for the first time on appeal pose a new theory

which builds upon a factual situation that was open to controversy and which was not placed in issue or presented to the trial court. (Jiminez v. City of Oxnard (1982) 134 Cal.App.3d 856,859.) Appellant had ample oportunity to challenge the presentation and designation of evidence at the administrative hearing. Indeed, appellant could, and arguably should, have requested that his own expert witnesses permanently denote those portions of the X-ray films which advanced his position that surgical intervention was necessary to relieve his patients of their symptoms.

At the administrative hearing, the ALJ granted appellamt's request that general packages of X-rays be marked for identification. Further, the ALJ specifically marked those X-rays which one of the Board's experts, radiologist Dr. Grollman, said particularly illustrated his points. There is no indication that appellant could not also have asked that individual features be marked on each X-ray

film in conjunction with proffered testimony.2/

Nevertheless, appellant maintains that the absence of pertinent markings on the X-ray evidence precluded adequate

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2. Appellant argues that an agency record, like that of the Board's, must provide as complete a basis for judicial review as due diligence makes feasible and that such record must include any technical matter necessary to enable a lay judge to determine whether the agency's decision has adequate support. He relies for this proposition on the holding in Franz v. BMQA (1982)31 Cal.3d 124, 139. However, Franz was decided a year after appellant's hearing was concluded. Moreover, we find little logic in appellant's inference that if the Board was responsible for denoting precise radiographic features in case of judicial review, that appellant was thereby relieved of having to permanently mark those features which allegedly favored his own angiographic interpretations.

independent judicial review of technical questions central to the Board's Accusation and that this effectively deprived the trial court of jurisdiction over appellant's case. He states that a lack of jurisdiction can never be waived and may be raised at any point in the proceedings.

While the trial court is confined to the record of the agency hearing, we do not agree that the court was deprived of jurisdiction for want of more precisely marked X-rays. The issue of radiographic interpretation was fully and fairly litigated. In denying appellant a peremptory writ of mandate, the trial court specifically stated that it had read and considered the complete reporter's transcript of the administrative hearing and reviewed all xrays and exhibits. The court concluded that appellant had been afforded a fair trial and that there was no prejudicial abuse of discretion. In making its determination, the court stated that it had "exercised its independent judgment on the evidence" and had "determined that the

findings of [the] Division of Medical Quality of the Board of Medical Quality Assurance [were] supported by the weight of the evidence, and [that] its decision [was] supported by the findings...."

We find that the trial court was able to render an independent judgment on the record before it and that there was no want of jurisdiction which would justify raising the issue of radiographic designations for the first time on appeal.

II

Appellant's next contention follows upon his first. He argues that the Board failed to meet its initial burden of presenting the trial court with an adequate record and that the trial court consequently erred in giving him the burden of proving error. We do not agree.

When the findings of an administrative agency come before the trial court, the burden is upon the complaining party to convince the court that the agency's decision is contrary to the weight or preponderance of

the evidence. (Chamberlain v. Ventura County Civil Service Com. (1977) 69 Cal.App.3d 362, 368-369.) Here, the trial court specifically held that the findings of the Board's Division of Medical Quality Assurance were "supported by the weight of the evidence."

Appellant, however, maintains that the presumption of correctness which ordinarily would attach to an agency's decision is not operative here, since the Board failed to meet its preliminary burden of providing the trial court with an adequate record. As noted in our discussion above, we do not find that the trial court was incapable of rendering an independent judgment on the record before it or it lacked jurisdiction to do so. Even assuming this issue could be raised for the first time on appeal, we find no abuse of discretion.

III

Appellant next contends that the findings implied in the trial court's judgment are not supported by the evidence.

He argues that the reviewing court should abandon the substantial evidence standard of appellate review and adopt either the standard of clear and convincing proof to a reasonable certainty or the standard of a preponderance of the evidence. e reasons that this must be done because the Board did not create a record sufficient to permit the trial court to exercise its independent judgment. We find no merit in appellant's contention.

At the outset, we note that even though a trial court must exercise independent judgment on the evidence in an administrative mandamus proceeding, its findings are sustained on appeal is supported by substantial evidence on the whole record. (Franz v. BMQA , supra, 31 Cal.3d at p. 135.)

In the instant case, appellant attacks the credibility of respondent's witnesses. However, the credentials of the experts has already been litigated. While expert

surgery involving of the 22 patients, we find no abuse of discretion in the court's determinations.

When varying inferences can be reasonably deduced from the facts, the reviewing court is without authority to substitute its own deductions for those of the trial court. Conflicts in the evidence must be resolved in favor of the respondent, and all legitimate and reasonable inferences indulged in to uphold the judgment.

(Milligan v. Hearing Aid Dispensers Examining Com. (1983) 142 Cal.App.3d 1002.)

IV

The Accusation made against appellant charged him with "unprofessional conduct" under former section 2361 of the Business and Professions Code (now section 2234). Defendant contends that the charging statute is unconstitutionally vague and impermissibly delegated legislative authority to the Board. We find no support for appellant's argument.

Business and Professions Code section 2361, subdivisions (b) and (c), provided that

"[u]nprofessional conduct includes, but is not limited to, the following:...(b) Gross negligence. (c) Gross incompetence...."3/ Appellant maintains that the terms "gross negligence" and "incompetence" are virtually undefinable and do not provide courts and administrative agencies with an ascertainable standard of care against which medical conduct can be uniformly judged. He claims that this problem is exacerbated by the fact that the administrative record must be reviewed independently by a judge who

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3. By statutes 1980, chapter 1313, page 4473, section 2, the Legislature amended, repealed and reenacted the provisions of the Medical Practice Act, Business and Professions Code, sections 2000 et seq. The provisions of Business and Professions Code section 2361, subdivisions (b) and (c) became section 2234, subdivisions (b) and (d), respectively, effective January 1, 1981. However, the term "incompetence" now replaces the term "gross incompetence."

is untrained in medical matters and who is therefore unequipped to determine the appropriate standard of care. Appellant further argues that such a standard of care cannot be supplied by expert testimony at the time of the hearing. We disagree with appellant's analysis.

Where possible, a statute should be construed in favor of its validity and be viewed in accord with probable legislative intent. A statute is not to be declared void for vagueness or uncertainty "if any reasonable and practical construction can be given its language." (Shea v. Board of Medical Examiners (1978) 81 Cal.App.3d 564, 574.) When a statute is not sufficiently clear, it may be made more precise by judicial construction and by application of the statute in conformity with the legislative objective. (Shea , supra, 81 Cal. App.3d at p. 574; Morrison v. State Board of Education (1969) 1 Cal.3d 214, 232.)

The purpose of the statutory provision under which appellant was charged is to

insure a high quality of medical practice. (Shea , supra, 81 Cal.App.3d at p. 574.) In so doing, section 2361 provides that "[u]nprofessional conduct includes, but is not limited to" certain enumerated conduct. This does not suggest, however, that an overly broad connotation may be given the phrase "unprofessional conduct"--it must encompass conduct which "indicates an unfitness to practice medicine." (Shea , supra, 81 Cal.App.3d at p. 575.) Although the term "gross negligence" is not expressly defined in the Business and Professions Code, it is generally accepted as an "extreme departure from the ordinary standard of care." (Gore v. BMQA (1980) 110 Cal.App.3d 184, 197-198.)

In the case at bar, sufficient evidence exists to support the trial court's finding that appellant frequently failed to perform appropriate neurological studies and patient workups and that his readings of angiographic film was often a questionable basis for the surgeries he performed. The concept of

"unprofessional conduct" does not require specific legislative enumeration as to the precise deviations which fall within its definitions." (Shea , supra, 81 Cal.App.3d at p. 575.) Here, a number of physicians testified that the diagnosis and treatment rendered by appellant constituted an extreme departure from the ordinary standard of medical practice and represented an incompetent discharge of appellant's professional medical responsibilities. (Gore v. BMQA , supra, 110 Cal.App.3d at p. 197.) We find that such expert opinions adequately established the standard of practice expected of a medical licensee in appellant's position and the reasons why appellant's actions constituted "unprofessional conduct".

Finally, we disagree with appellant's assertion that Business and Professions Code 2361 impermissibly delegates legislative authority to the Board. This argument rests on the assumption that the statute failed to delinate ascertainable standards with which

to guide the decision-maker and thus precludes effective review. The Board in this case relied on competent medical professionals to interpret and apply the Legislature's intent concerning "unprofessional conduct." As noted above, we do not find that the charging statute was unconstitutionally vague or that its meaning could not be given practical construction.

The judgment is affirmed.

NOT TO BE PUBLISHED

FEINERMAN, P. J.

We concur:

ASHBY, J.

HASTINGS, J.

Honorable Leon Savitch, Judge
Superior Court County of Los Angeles

Glassman & Browning and David R. Hinden for Petitioner and Appellant.

John K. Van de Kamp, Attorney General and M. Gayle Askren, Deputy Attorney General, for Respondent.

ADOPTED DECISION OF

BOARD OF MEDICAL QUALITY ASSURANCE

A29

BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against:

SEYMOUR ALLEN HURVITZ, M.D.

Certificate No. G-3690

Respondent.

NO. D-2250

L-18015

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Medical Quality Assurance as its Decision in the above-entitled matter.

This Decision shall become effective on March 16, 1984.

IT IS SO ORDERED February 15, 1984.

DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

/s/ Miller Medearis

MILLER MEDEARIS

Secretary-Treasurer

BEFORE THE DIVISION OF MEDICAL QUALITY

BOARD OF MEDICAL QUALITY ASSURANCE

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against:

SEYMOUR ALLAN HURVITZ, M.D.

2080 Century Park East, Suite 508

Los Angeles, California 90067

Physician and Surgeon

Certificate No. G-3690,

Respondent.

NO. D-2250

L-18015

PROPOSED DECISION

This matter came on regularly for hearing on November 13, 1980 and on various dates thereafter ending February 19, 1981, at Los Angeles, California, before Kenneth Cameron, Administrative Law Judge of the Office of Administrative Hearings. Complaintant was represented by M. Gayle Askren, Deputy Attorney General. Respondent was represented by Roger L. Cossack and

Robert C. Baxley, Attorneys at Law, Baxley appearing only to present argument on certain issues of law. Complainant filed a Motion to Amend Accusation, which was granted. Evidence, oral and documentary and by way or oral stipulation was received, written argument was received and the matter was submitted on May 4, 1981. The Administrative Law Judge makes the following findings of jurisdictional fact and preliminary rulings:

I

Jurisdictional Facts

Complaintant Robert C. Rowland, Executive Director of Board of Medical Quality Assurance, hereinafter "Board", made and filed the Accusation solely in his official capacity.

II

On August 24, 1956, the Board of Medical Examiners, predecessor to the Board, issued physician's and surgeon's certificate number G-3690 to respondent Seymour Allan Hurvitz, M.D. Said certificate is currently in full force and effect.

III

Motion to Exclude Medical Records

A. 1. Respondent moved to exclude hospital patient records and radiographic plates pertaining to the 22 patients named in the Accusation, citing Board of Medical Quality Assurance v. Gherardini, (1979) 93 Cal.App.3d 669, petition for hearing denied August 8, 1979. This motion was argued orally and was taken under submission, subject to further argument, in writing, and the records were admitted conditionally, subject to a motion to strike.

2. In 1977, an investigator for the Board, pursuant to an investigational subpena duces tecum, obtained patient records and radiographic plates from three hospital, without patient authorization; in 1977, an investigator for the Board, pursuant to such a subpena, obtained from respondent radiographic plates taken by him from hospitals, without patient authorizations and shown by him to other physicians; patient records for two patients were obtained

voluntarily, without subpena, from the Los Angeles County Medical Association. All these records were reviewed by other physicians.

3. The contents of one subpena and the declaration in support of subpena are in evidence; there is no specific evidence as to facts in possession of the investigiator(s), as grounds for issuance of subpenas. There is no evidence that any of the 22 patients in the present case complained to the Board about respondent.

4. Complainant argues, among its grounds for opposing said Motion, that Gherardini should not be given retroactive effect and that, in any event, an exclusionary rule should not be applied because the investigator(s)'s conduct was blameless, under the law as then in effect, also, that the hospitals and respondent effectively waived the patient-physician privilege.

5. The Accusation, dated October 23, 1978, was served on respondent on October 31,

1978 and filed with the Office of Administrative Hearings on November 1, 1978. It gives the patients' names and details facts, or alleged facts, obtained from the patient records and radiographic plates, including medical history, symptoms, diagnoses, etc.

6. Three patients (Soliz, Tanner and Toomey) appeared at the hearing and gave evidence regarding their medical history, without asserting any privilege. Patient Levine wrote a statement on April 7, 1977 favorably describing his surgery and its results and stating that, if called upon to testify in court, he would do so. Patient Cornelius was deceased when her records were obtained.

B. 1. Evidence Code Section 1007 provides an exception to the physician-patient privilege "in a proceeding brought by a public entity to determine whether a right, authority, license or privilege...should be revoked, suspended, terminated, limited or conditioned."

Gherardini is based on the right of privacy found in Article I, Section 1, California Constitution, as reworded by amendment in November, 1974, and in the Fourth Amendment to the Federal Constitution. Gherardini holds that 'minimal due process requirements' to protect the third party patient's consitutionally protected right of privacy, must be interposed to hold Evidence Code Section 1007 constitutional. Government Code Section 11513(c) provides that, in a proceeding under Government Code Section 1150 et seq. (Administrative Procedure Act), the rules of privilege shall be effective to the extent that they are otherwise required by statute to be recognized at the hearing. Government Code Section 11183 prohibits a State officer from divulging any confidential or private information acquired pursuant to an investigiational subpena except when called upon to testify in any court ot proceeding at law. Evidence Code Section 351 provides that, except as otherwise provided by statute, all relevant evidence is

admissible. Under Evidence Code Section 664, it is presumed that official duty has been regularly performed.

2. Under Brovelli v. Superior Court (1961) 56 Cal.2d 524, an officer of a State agency may isssue subpenas for the production of documents in any inquiry, investigation, hearing or proceeding pertinent to matters under the jurisdiction of the agency, pursuant to Government Code Sections 11180 and 11181, without instituting formal proceedings but with due regard for the privilege against self-incrimination and for the prohibition of unreasonable search and seizure.

3. In Gherardini , a superior court issued an order granting a petition of the Board of Medical Quality Assurance commending a hospital and its custodian to testify and produce hospital records and documents pertaining to five named patients of a certain doctor. The investigator's declaration in support of the subpena deces tecum alleged that he was conducting an

investigation involving an allegation of gross negligence and/or incompetence in the treatment of patients by the named doctor and that the medical records might offer evidence to substantiate the allegations. The declaration alleged neither patient consent nor complaint, contained no specific charge by a fellow physician or member of the public , and gave no facts supporting its conclusionary statements. Upon the hospital's refusal to surrender the records, the Board sought and obtained the challenged order. The appellate court reversed and remanded.

4. The statutory scheme for regulation of the medical profession includes provisions of the Medical Practice Act (Section 2000 et seq. Business and Professions Code), pertaining to hospital records, physicians' office records and inspection thereof. Sections 2392.5 and 2392.6 proscribe treatment of patients in a hospital which does not have rules requiring adequate and accurate medical records to be

prepared and maintained for all patients. Section 2122.5 grants to members of the Division of Medical Quality of the Board authority to inspect patient hospital medical records; such authority may be delegated to any license physician; such authority is subject to the provisions of Section 2379, which reads: "The willful betraying of a professional secret constitutes unprofessional conduct within the meaning of this chapter. Neither this section nor any other provision of law making communication between a physician and surgeon, or podiatrist, and his patient a privileged communication shall apply to investigations or proceedings conducted under this act. The board and examining committee, its employees, agents and representatives must keep in confidence during the course of investigations under this act, the names of any patients whose records are reviewed and may not disclose or reveal such names unless and until proceedings are instituted. The board's authority to examine records of

patients in the office of a physician and surgeon is limited to records of patients who have complained to the board about a particular physician physician and surgeon. Waiver of privilege shall not apply to investigations under Section 2417."

5. Under Gherardini , the standard of investigative conduct is that patients' privacy should not be invaded without consent or good cause. In the present case there was no consent. Good cause (or probable cause) means a factual exposition of a reasonable ground for the request (to inspect records), such as to satisfy an impartial tribunal that the request may be granted without abuse of the inherent right of an adversary and without abuse of a third party's constitutionally protected right of privacy. Incursions into the individual zone of privacy must be justified by a compelling state interest. On a motion to exclude evidence obtained by an allegedly illegal inspection, the burden is on the movant to show the illegality. Here, although lack of

consent is proved and the subpenas are arguably defective, there is no other evidence as to good cause, except the negative fact of no patient complaint. That one fact is insufficient to dispel the presumption of regularity under Section 664, Evidence Code.

6. Good cause existed for issuance of the subpenas and for inspection of hospital records and radiographic plates; there is a compelling state interest in enforcing standards of medical care.

7. Even if a lack of good cause for issuance of the subpenas, under the Gherardini standard, were proved, there remains a question as to the admissibility of evidence, including the documents themselves, obtained pursuant to the subpenas, once a formal proceeding has begun and a hearing convened. Between the time of issuance of the subpenas and the filing of the Accusation, several physicians had examined the records. The Accusation, which discloses in detail medical profiles of the patients,

is a public record. By these events the patients' rights of privacy have been irreparably injured. The situation is not like that presented to the Gherardini court, where the custodian of the patients hospital records resisted the subpena in timely fashion. Here, neither the hospitals nor the physician (respondent) objected to the subpenas. If they had, there would have been an opportunity to test the sufficiency of the subpenas, facially, and as to reasonable grounds for issuance. If the subpenas were found insufficient, the investigator might have supplied the deficiency or might, alternatively, have obtained the consent of at least some of the patients. Those opportunities having been lost, about a year before the beginning of the formal proceeding, and public disclosure of patients'medical profiles having occurred, it becomes necessary now to fashion a procedure in which the rule of Gherardini may be applied in new and different setting. The waters have flowed over the dam and are now

far downstream.

8. The applicable constitutional and statutory provisions, as interpreted by the Gherardini court, require a balancing of competing interests, the patients' interest in privacy and the public interest in fair enforcement of laws regulating the medical professions, in the light of present facts. Certain patients waived their rights of privacy by testifying or offering to testify. It is impossible to undo the injury already done to the other patients' interest or even to remedy that injury in any particular way. To exclude the evidence of patient records now would be a futile exercise and would only serve to defeat the public interest in having an adjudication, after a hearing in which all relevant evidence can be considered. Applying the Gherardini standard to the extent reasonably possible, exclusion of the evidence in question is not required; any possibility of further harm to patients' rights is outweighed by the public interst at stake.

9. Application of a vicarious rule, based on the "fruits of the poisonous tree" doctrine, is not justified on the facts of the present case. At the time of production of the records pursuant to investigational subpenas, the procedures followed by the investigator(s) were apparently lawful under Government Code Sections 11180 and 11181 as interpreted in Brovelli , supra, and under Sections 2392.5, 2392.6, 2122.5 and 2379, Business and Professions Code.

10. Respondent's motion to exclude evidence of medical records is denied.

IV

Constitutionality of Statutes

A. Respondent has adduced argument that the statutes invoked by complainant, Sections 2361(b) and (d), Business and Professions Code, relating to unprofessional conduct by physicians, are defective under due process and equal protection (uniform operation) provisions of the Federal and State Constitutions.

B. Respondent argues unconstitutionality

of said statutes facially, not as applied to particular facts.

C. Under Article III, Section 3.5, State Constitution, administrative agencies are prohibited from declaring a statute unenforceable on the basis of unconstitutionality, or unconstitutional, unless an appellate court has so determined. No appellate court has so determined as to the statutes in question. Consequently, the Board and the Administrative Law Judge have no authority to inquire into the constitutional issues raised by respondent.

* * * * *

The Administrative Law Judge makes the following substantive findings of fact:

V

1. During the period October, 1974 through April, 1976, respondent provided medical care, including surgery on the vertebral artery or arteries, to twenty-two individuals, hereinafter "patients", identified by letters A through V, as in the Accusation, and by initials.

2. Respondent is a Board-certified general surgeon (1963) and a Board-certified thoracic and cardiac surgeon (1967). He has performed about 400 vertebral artery surgeries.

3. a. On each patient respondent performed surgery which he terms "reconstruction" of a vertebral artery. He describes the procedure as consisting of arteriolysis and decompression of the vertebral artery, removal of compressing tissues, ligation of internal mammary artery (if posssible), ligation of suprascapular artery (if possible), perivascular vertebral artery sympathectomy and anterior scalenotomy. The object of the procedure is to revascularize the brainstem.

b. Respondent believes that extralumenal compression of one or both vertebral arteries is a major factor in vertebral-basilar artery insufficiency (hindbrain ischemia).

4. The findings which follow are based on evaluation of testimony of expert

witnesses, including respondent, who had examined the patient records and radiographic plates, and on numerous learned articles in medical literature. Conflicts have been resolved by preponderance of evidence.

VI

Findings as to Particular Patients

A. (D. W.)

1. (a) Patient A, a 58 year-old woman, was hospitalized by respondent on February 22, 1976. Respondent recorded the patient's chief complaint as "Elective admission for left vertebral artery surgery" and a history of progressive dysphagis for 5 years, esophageal work-up negative, equilibrium disorder, dizziness in upright position, syncopal attacks, and slurred speech - 9 months.

(b) From December 1 to 3, 1975, patient had been hospitalized by respondent and discharged without operation or treatment. Respondent gave the final diagnosis on discharge of December 3, 1975 as hindbrain ischemia with dysphagia and recent

syncopal attack and a secondary diagnosis of diabetes mellitus.

(c) Dr. Goodman, the patient's personal physician, had an aortic arch angiogram performed. The angiograms are not in evidence. Respondent noted: "Angiogram shows marked narrowing of the proximal left vertebral artery." Respondent's tentative diagnosis was partial obstruction of proximal left vertebral artery with hindbrain ischemia. On February 23, respondent performed surgery on the left vertebral artery.

2. Respondent failed to perform or to have performed an adequate neurological evaluation.

3. Respondent's discharge summary of February 27 gives patient's response to treatment as "excellent, dysphagia and dizziness disappeared. Equilibrium and speech improved."

4. The patient told Dr. Goodman that the benefits obtained in relief of her symptoms were temporary.

B. (J. W.)

1. Patient B, a 46 year-old man, was hospitalized by Dr. Slocum on September 19, 1975 with an admitting diagnosis of myositis of lower extremities with partial paralysis. The admitting physician did a history and physical, noting an apparent drop attack and seeming muscular dystrophy. At the request of Dr. Steller respondent saw the patient in consultation on September 24, gave his diagnosis as "hindbrain ischemia" and "Question obstruction 1st part vertebral arteries." Respondent ordered, with the concurrence of Dr. Slocum, an aortic arch angiogram with visualization of neck vessels, which was performed September 29. Respondent evaluated it as showing partial obstruction of origin and proximal right vertebral artery . The hospital radiologist (Dr. Khani) found good evidence of filling with contrast material in the vertebral arteries; mild tortuosity of the left vertebral artery. On October 1, respondent performed surgery on the right vertebral artery.

2. Respondent failed to have sufficient neurological laboratory studies and to perform or have performed an adequate neurological evaluation.

3. The angiogram does not show any significant abnowmality in the right vertebral artery.

4. On discharge on October 14, 1975 respondent noted the patient's response to treatment as "excellent." The patient was ambulatory but still had complaints on October 11 of headaches, dizziness and anxiety.

C. (E. H.)

1. Patient C, an 80 year-old woman, was hospitalized by respondent on April 30, 1975, with a chief complaint and present history of severe difficulties with equilibrium - 6 months, unsteady gait and several recent falls. Respondent recorded the past history as diabetes mellitus. His admitting diagnosis was brain stem ischemia. He had an aortic arch angiogram performed in which he found a kink occlusion of proximal vertebral

artery, with delayed filling, and a partial kink of the proximal right vertebral artery. The hospital radiologist (Dr. Khani) found moderate tortuosity bilaterally with suggestion of slight kinking at origin of left vertebral artery, no evidence of obstruction, moderate tortuosity and good filling of both vertebral arteries. On May 1, respondent performed surgery on the left vertebral artery. His diagnosis on discharge of May was extraluminal occlusion of left vertebral
artery with hindbrain ischemia with severe disorder of equilibrium.

2. Respondent failed to perform a complete history and a complete physical examination and to perform or have performed a neurological evaluation.

3. The angiogram does not show any significant abnormality of the left vertebral artery.

4. On discharge of May 3, respondent reported the patient's response to treatment as good.

D. (W. K.)

1. Patient D, a 64 year-old man, was hospitalized (re-admitted) jointly by respondent and Dr. Simmonds on July 21, 1975, with a chief complaint of Parkinson's diease. During a previous period of hospitalization, on June 23, 1975, respondent, in consultation, performed surgery on the left vertebral artery. Aortic arch angiograms were performed on June 19 and June 26. On July 22, respondent performed surgery on the right vertebral artery. His pre-operative diagnosis was partial obstruction of proximal right vertebral artery with symptoms of hindbrain ischemia. On July 28, respondent ordered a post-operative aortic arch angiogram which the radiologist (Dr. Khani) interpreted as follows: "Both vertebral arteries fill well bilaterally with no evidence of obstruction. There is no interval change in the size of the vertebral arteries as compared to the previous exam of 6-26-75."

2. Respondent failed to have appropriate

neurological laboratory studies performed and to perform or have performed an adequate neurological evaluation.

3. The angiography of June 19 and 26 does not demonstrate abnormalities requiring surgery.

4. The surgery of July 22 resulted in no anatomic changes.

E. (G.C.)

1. (a) Patient E, a 79 year-old woman, was hospitalized by Dr. Slocum on October 2, 1974, with symptoms of dizziness, poor equilibrium, shortness of breath and shakiness of her head. Respondent saw the patient in consultation on October 10, and made a diagnosis of possible vertebral-basilar artery insufficiency with stenosis of origin of vertebral artery. On October 11, on respondent's orders an aortic arch angiogram with study of neck vessels was performed. Respondent found proximal occlusion of large left vertebral artery and poor filling of right small vertebral artery; the radiologist (Dr. Khani) found hypoplastic

(underdeveloped) right vertebral artery in its entire course and kinking with slight narrowing at the origin of the left vertebral artery, with good filling of the left vertebral artery with contrast material. On October 15, respondent performed surgery on the left vertebral artery.

(b) Patient E was hospitalized a second time by Dr. Slocum on June 25, 1975, with a chief complaint of vertigo. Dr. Slocum noted that the left vertebral surgery of October, 1974 "gave great relief with symptoms" and that the right vertebral shows extraluminal occclusion. Respondent's report of consultation notes disturbance of equilibrium and occipital headaches for past 3 months and the previous surgery for "similar symptoms." His diagnosis was partial obstruction proximal right vertebral artery with hindbrain ischemia. On June 27 he performed surgery on the proximal right vertebral artery.

2. Respondent failed to perform or to have performed an adequate neurological

evaluation.

3. The angiography does not show obstruction or occlusion of either vertebral artery.

4. Surgery on a hypoplastic vertebral artery, eight months after surgery on the other (larger) vertebral, is not likely to be beneficial.

5. Respondent noted improvement in the patient's alertness and balance following the surgery of June 27, 1975. In a sworn declaratioin of July 20, 1977, Patient E stated: ".....After the operations, my balance and walking improved and are 75% better today than before the operations. The headaches were also helped greatly....."

F. (J. K.)

1. Patient F, a 75 year-old man, on referral by Dr. Rubinstein, was hospitalized by respondent on June 8, 1975, with a present history of "Severe disorder with equilibrium 6 months...[using] cane past 4 months. Had fear of falling. Able only to take small steps and walks slowly." Respondent's

admitting diagnosis was hindbrain ischemia. On June 10, 1975, at respondent's request, an aortic arch angiogram was performed, in which he found partial obstruction of origin and proximal right vertebral artery, kink of right vertebral artery 2 centimeters beyond origin; the radiologist (Dr. Khani) evaluated it as showing tortuosity with kinking, with an angulation approximately 1 1/2 centimeters from origin of the right vertebral artery, both vertebrals filling well with no definite evidence of obstruction. On june 12, respondent performed surgery on the proximal right vertebral artery.

2. Respondent failed to perform a complete history or a complete physical examination or to perform or have performed an adequate neurological evaluation.

3. The angiograms do not show any obstruction of the right vertebral artery.

G. (J. F. D.)

1. Patient G, a 70 year-old man, was hospitalized by Dr. Steller on April 10, 1975, for evaluation of severe syncope and

staggering gait. Dr. Azadeh, an internist, performed a medical consultation on April 11 and recorded an impressionof arteriosclerotic heart disease with recent episodes of chest pain, cardiac arrhythmia, possibility of impending myocardial infarction. Respondent saw the patient in consultation on April 11, did a history and physical and gave a diagnosis of hindbrain ischemia, question of occlusion of origin of left vertebral artery. He recommended angiography with study of neck vessels, which was performed. In this study respondent found a severe occlusion of origin of right vertebral artery with very poor filling of right vertebral artery in the neck; the radiologist (Dr. Khani) found the right vertebral artery smaller in caliber than the left and small angulation at origin of left vertebral artery with no definite evidence of obstruction. On April 15, respondent performed surgery on the proximal right vertebral artery.

2. Respondent failed to perform or to have performed an adequate neurological

evaluation.

3. Respondent caused the patient to undergo angiography and surgery in apparent disregard of the consultant's report indicating the possibility of impending myocardial infarction.

4. The pre-operative angiography does not show occlusion or obstruction of the right vertebral artery.

5. On April 19, respondent noted that the patient's balance and walking were normal. On April 22 the patient was discharged as "recovered" and "improved".

H. (S.T.)

1. (a) Patient H, a 70 year-old woman, was hospitalized by Dr. Gross, on February 18, 1975, because of severe chest pains, coronary insufficiency, pancreas disease and diabetes. On February 19, respondent, in consultation, made a diagnosis of vertebral-basilar artery insufficiency with cerebellar ataxia, possible recurrent esophagitis. He advised an arch angiogram with study of neck vessels. Dr.

Grossmordered it and on February 26, respondent evaluated it as showing occlusion of origin of left vertebral artery; the radiologist (Dr. Khani) evaluated it as indicating kinking at origin of left vertebral artery, normal right vertebral artery. On February 27, respondent performed surgery on the left vertebral artery.

(b) This patient was hospitalized a second time by Dr. Gross on July 18, 1975, for recent staggering, loss of accuracy in use of hands last few days, dysarthria last few days, cough one month, left chest pain long time and headaches long time. Respondent saw the patient in consultation on July 21. He noted: "Recurrent symptoms of hindbrain ischemia - headache, equilibrium disorder, headache, decreased ability to knit - past 1 month. Arch angiogram in February 1975 showed partial obstruction both proximal vertebral arteries. Reconstruction left vertebral artery performed 2/27/75 with good symptomatic improvement for 3 months. Advise: Reconstruction proximal

right vertebral artery." On July 25, 1975, respondent performed surgery on the right vertebral artery.

2. Respondent failed to perform or to have performed an adequate neurological evaluation.

3. The angiography does not show occlusion of origin of the left vertebral artery, or partial obstruction of both vertebral arteries.

4. On December 10, 1980, this patient, now 76 years of age, described herself as feeling fine for about three months after the first surgery, then feeling bad again until the second surgery, then recovering quickly from her difficulties in walking and using her hands; she has felt "wonderful" since the second surgery, except for a problem of low pressure in 1980.

I. (J. L.)

1. (a) Patient I, a 76 year-old man, was hospitalized by respondent on March 30, 1975. Respondent noted present history as severe vertebro-basilar artery insufficiency with

cerebellar ataxia, dysarthria, dysphagia and headache. Respondent's examination revealed slurred speech and cerebellar ataxia. He noted a period of hospitalization in 1975 with a discharge diagnosis of advanced cerebellar degeneration. On March 31, respondent ordered an aortic arch angiogram which he evaluated as showing complete occlusion of origin of left vertebral artery; the radiologist (Dr. Khani) evaluated it as indicating very slow flow into left vertebral artery, which is small in caliber, suggestive of possible stenosis at its origin, right vertebral normal with no evidence of obstruction. On April 1, respondent performed surgery on the left vertebral artery. On the same date, at respondent's request, a cardiolgist consultant evaluated patient before surgery and reported heart disease, pacemaker in place and cerebrovascular arteriosclerosis. A post-operative angiogram (plates not in evidence) was performed on April 3, as to which the radiologist reported that poor

filling of the left vertebral artery was essentially unchanged from the first angiogram.

(b) Patient I was hospitalized again by respondent on July 15, 1975, for recurrent equilibrium and dizziness of two weeks duration. In the admission history respondent wrote that the angiogram previously performed showed partial obstruction of proximal right [sic] vertebral artery. On July 17, respondent performed surgery on the right vertebral artery.

2. Respondent failed to perform a complete history or a complete physical examination, or to perform or to have performed an adequate neurological evaluation, particularly to rule out cerebellar degeneration.

3. The angiography does not show complete occlusion of origin of the left vertebral artery or partial obstruction of the right vertebral artery.

4. In the admission history of July 15, respondent noted that the surgery of April 1

had "excellent result-elimination of dysphagia and headache, improved speech." On discharge of July 21, 1975 respondent noted patient's response to treatment as excellent.

J. (L. H.)

1. Patient J, a 25 year-old man, was hospitalized by Dr. Slocum on April 29, 1975, for evaluation of convulsive seizures and syncopal episodes - past 3 years, with recent falls. Dr. Slocum performed a history and physical examination and gave a tentative diagnosis of epilepsy. Dr. Slocum's history shows that patient had suffered from depression, had been a patient in a State mental hospital in 1969 and 1972; he is described as sluggish and retarded. Respondent saw the patient in consultation on April 30, recorded a brief history and physical, made a diagnosis of question of hindbrain ischemia with symptoms, and advised an arch aortogram with study of neck vessels, which was performed on May 2. On May 2 a neurosurgeon consultant, Dr. Penka, reported an impression of syncopal episodes of unknown

etiology and advised diagnostic investigation; he noted partial occlusion of left vertebral artery in the arch study and a possibility of cerebrovascular insufficiency as one of the four possible causative factors. Respondent found definite extraluminal partial occlusion of origin and proximal left vertebral artery; the radiologist (Dr. Khani) found no evidence of obstruction in the course of the vertebral arteries bilaterally. On May 5, respondent performed surgery on the left vertebral artery.

2. Respondent failed to give adequate consideration to the neurological evaluation.

3. The angiography does not show occlusion or obstruction of the left vertebral artery.

K. (A. V. C.)

1. Patient K, an 80 year-old woman, was hospitalized by Dr. Pearson on April 4, 1975, for evaluation of numbness of right arm, speech difficulty and confusion of one day duratioin. Neurological consultations were

had. On April 5, a neurologist (Dr. Rich) reported his impressions: "Probable cerebrovascular accident involving the left middle cerebral artery distribution, etiology not determined...arteriosclerotic cerebrovascular and cardiovascular disease...rule out underlying vascular malformation..." He recommended further diagnostic studies. On April 11, respondent, as consultant, evaluated an aortic arch angiogram, ordered by Dr. Pearson, as showing partial occlusion of origin of left vertebral artery; the radiologist (Dr. Saenz) evaluated it as showing moderate to marked narrowing of right verebral artery at its origin, left vertebral artery appearing to end at the PICA (posterior inferior cerebellar artery). Respondent's diagnosis was partial occlusion of left vertebral artery with brain stem ischemia. On April 14 respondent performed surgery on the proximal left verebral artery and "reconstruction of collateral circulation to upper vertebral artery." On April 21 a post-operative angiogram was performed on

respondent's orders, with the tacit approval of a consulting neurologist; it was evaluated by the radiologist (Dr. Duncan) as demonstrating essentially no change. Respondent found "complete patency".

2. Respondent failed to give adequate consideration to the neurological findings, which do not conform to his diagnosis of brainstem ischemia.

3. The pre-operative angiography does not show partial occlusion of origin of the left vertebral artery; it shows that vessel ending at the PICA, thus not contributing to circulation in the brainstem. The post-operative angiography does not show any anatomical change in that vessel.

4. Respondent noted on April 18 that, since surgery, the patient's hearing was much improved, resulting from increased blood flow through left vertebral artery to brainstem area of 8th cranial nerve. One of the neurologists (Dr. Whitehead) reported on April 22 that there had been no definite alteration, other than an improvement of the

hearing, subsequent to the surgery.

5. Patient K expired in thehospitalon May 1, 1975.

L. (M. G.)

1. Patient L, a 91 year-old woman, was hospitalized by Dr. Pearson on April 8, 1975, for evaluation of weakness of left arm and leg, lethargic and confused. Patient's admission EKG was abnormal. On April 8, respondent, in consultation, made a diagnosis of left hemiparesis and probable brainstem ischemia, rule out occlusion of left vertebral artery. He advised an aortic arch angiogram which was performed on April 9. In it he found occlusion of origin of left vertebral artery and high-grade stenosis of origin of right internal carotid artery; the radiologist (Dr. Duncan) evaluated it as indicatinga 98 percent stenosis of the right internal carotid artery with post-stenotic dilatation, marked tortuosity of both vertebral arteries with diminished filling of the left vertebral artery. On April 9 respondent performed surgery on the left

vertebral artery. In a post-operative angiogram he found excellent filling of left vertebral artery; the radiologist confirmed this finding. On April 12, a cardiologist was called in for consultation because of intermittent bradycardia.

2. Respondent failed to perform a complete neurological evaluation or, in the alternative, to obtain a neurological consultation or to obtain a cardiovasculr consultation before ordering angiography and performing surgery;
hee failed to recognize the probability of carotid artery disease as the major problem requiring attention.

M. (H. F. M.)

1. Patient M, a 72 year-old man, was hospitalized by respondent on April 1, 1975, for evaluation of severe disorder of equilibrium for five days prior to admission. The patient had hypertension. On April 2, a neurological consultant (Dr. Treciokas) gave his impression as six in number, of which the first was probable

vertebral vascular insufficiency. The consultant recommended diagnostic studies including an angiogram. On April 2, on respondent's order, an aortic arch angiogram was taken; the radiologist (Dr. Duncan) found occlusion of left vertebral artery and severe stenosis with ulceration of the left internal carotid artery; respondent's evaluation was the same. On April 2, respondent performed surgery on what he took to be the left vertebral artery; the patient had suffered a stroke on that date before the angiography was performed. On respondent's recommendation, a post-operative arch angiogram was performed on April 8, which respondent evaluated as indicating some improvement, i.e., delayed filling of upper portion of left vertebral artery; the radiologist interpreted it as revealing no change.

2. The surgery was actually performed, by mistake, on the costo-cervical trunk, not on the vertebral artery.

3. Respondent failed to perform a

complete history or to have performed appropriate diagnostic studies other than the angiography, or to obtain a medical consultation as to the patient's hypertension and cerebrovascular disease, before undertaking surgery on the vertebral artery.

4. The post-operative angiography disclosed no anatomic change in the left vertebral artery.

5. On April 3 and 4 respondent noted remarkable recovery of motor power of left limbs, slurred speech gone, handwriting improved. After continued improvement, on April 14, respondent performed surgery on the left internal carotid artery (endarterectomy). The patient's condition deteriorated and he became comatous on April 15.

N. (M. P.)

1. (a) Patient N, a 70 year-old woman, was hospitalized by Dr. Steller on June 16, 1975, for evaluation of severe dizziness and syncope. On June 17, respondent, in consultation, gave a diagnosis of hindbrain

ischemia. Respondent advised an aortic arch angiogram. In it he found a severe kink occlusion of left vertebral artery 2 centimeters beyond its origin and kink occlusion of right vertebral artery; the radiologist (Dr. Khani) found moderate tortuosity of both vertebral arteries with smaller left vertebral artery, angulation and kinking approximately one centimeter from origin of left vertebral, both vertebral arteries filling well with no definite evidence of obstruction. An internist consultant was of the opinion that the patient's dizziness could be caused by nervousness or by pathology in the cerebellum. The patient did not want surgery and was discharged.

(b) On July 16, Patient N was readmitted by respondent. On July 17 he performed surgery on the proximal left vertebral artery.

2. Respondent failed to perform a complete neurological evaluation or to obtain a neurological consultation.

3. The angiography does not disclose any significant obstruction of the left vertebral artery.

4. On discharge of July 23, respondent noted the patient's response to treatment as excellent.

O. (M. B.)

1. Patient O, an 87 year-old man, was hospitalized by Dr. Slocum on July 20, 1975, with Parkinson's disease known for two years. On July 21 respondent, in consultation, gave a diagnosis of symptoms of hindbrain ischemia, question of partial obstruction of proximal vertebral arteries. On July 22, on Dr. Slocum's orders and on respondent's advice, an aortic arch angiogram was done, in which respondent found partial obstruction proximal right vertebral artery; the radiologist (Dr. Khani) found some beading of proximal one centimeter of right vertebral artery with suggestion of atherosclerotic changes or extrinsic pressure, left vertebral artery tortuous in its course, both vertebral arteries filled with contrast material. An

internist consultant recommended continued medication, nothing more, for Parkinsonism. On July 24, respondent performed surgery on the right vertebral artery.

2. Respondent failed to consider neurological laboratory studies ordered by Dr. Slocum before having the angiography performed, he failed to perform or have performed an adequate neurological examination.

3. The angiography discloses no significant abnormality in the right vertebral artery.

4. On discharge of August 1, respondent noted the patient's response to treatment as good, balance improved, tremor lessened.

5. Parkinson's disease is not treatable by correctioin of abnormalities in the vertebral arteries.

P. (A. A.)

1. Patient P, a 62 year-old woman, was hospitalized by respondent on June 2, 1975, for evaluation of severe disorder of equilibrium of six months duration, several

recent falls, dysarthria, disorder of vision and depression - 1 year. is tentative diagnosis was hindbrain ischemia, rule out obstruction of proximal vertebral artery. On June 4, at respondent's request, an aortic arch angiogram was performed in which he found partial obstruction of origin of right vertebral artery and kink of proximal left vertebral artery; the radiologist (Dr. Khani) found suggestion of stenosis at origin of right vertebral artery, moderate tortuosity of left vertebral artery, both vertebral arteries filling well. On June 5, respondent performed surgery on the right vertebral artery. On June 10, a postoperative arch angiogram was performed which respondent interpreted as showing excellent filling and patency of origin of right vertebral artery; evidence of a radiologist's opinion is to the contrary.

2.Respondent failed to perform a complete history or physical examination or to have performed an adequate neurological evaluation.

3. The pre-operative angiogram does not show obstruction of the right vertebral artery; the post-operative angiography shows no anatomical change.

4. On June 6, respondent noted that the patient's equilibrium was much improved, dizziness gone; on discharge of June 12, he noted reponse to treatment as excellent.

Q. (F. S.)

1. Patient Q, a 43 year-old woman, was hospitalized by respondent on June 15, 1975, after an office examination, for a chief complaint of severe disorder of equilibrium 3 months, with dizziness in the upright position and intermittent unsteady gait. Respondent's admitting diagnosis was hindbrain ischemia, rule out partial obstruction proximal veretbral artery. On June 16, respondent had performed an aortic arch angiogram in which he found partial obstruction of origin and proximal left verebral artery with delayed poor filling; the radiologist (Dr. Khani) found slight tortuosity of both vertebral arteries with

right vertebral being smaller than the left, no evidence of obstruction. On June 18, respondent did surgery on the left vertebral artery. In post-operative angiography respondent found "patent proximal left vertebral artery"; the radiologist found "lesser degree of tortuosity".

2. Respondent failed to perform or to have performed an adequate neurological evaluation.

3. The angiography does not show any significant lesion of the left vertebral artery or any significant change post-operatively.

R. (J. K.)

1. Patient R, a 35-year-old man, was hospitalized by respondent on April 5, 1976, for severe symptoms of hindbrain ischemia with right hemiparesis of one year duration. He had been hospitalized and evaluated neurologically about one year before, having been struck on the back of te head. On April 6, respondent had performed an aortic arch angiogram in which he found partial

obstruction of proximal 3/4 centimeter of right vertebral artery; the radiologist (Dr. Burrows) found a somewhat aberrant takeoff of right vertebral artery, no obstruction specifically. On April 8, respondent performed surgery on the right vertebral artery .

2. Respondent failed to perform a complete history or a complete physical examination or to perform or to have performed appropriate neurological studies or to obtain results of previous neurological studies; he failed to perform or have performed an adequate neurological evaluation.

3. The angiography does not show any significant lesion in the right vertebral artery.

4. Respondent noted improved functions post-operatively, in grip of right hand, improved speech, improved balance and other respects.

S.(B. L. J.)

1. Patient S, a 49 year-old woman, was

hospitalized by Dr. Steller on March 26, 1975, for evaluation of dizziness and loss of equilibrium for four to six weeks. Dr. Steller asked respondent to consult regarding cerebello-vascular vascular insufficiency. On March 27 angiography was performed which respondent, the radiologist (Dr. Khani) and an internist consultant interpreted as indicating complete occlusion of left vertebral artery. On March 28, respondent performed surgery on the left vertebral artery. Angiography was performed during surgery which respondent evaluated as demonstrating onset of blood flow up into vertebral artery not visualized on the previous angiogram. A post-operative angiogram, taken on April, was interpreted by the radiologist as indicating no change from the first study.

2. Respondent failed to perform or to have performed an adequate neurological evaluation.

3. The post-operative angiogram discloses no anatomic change.

4. On discharge of April 2 respondent noted the patient's response to treatment as excellent.

T. (D. M.)

1. Patient T, a 53 year-old man, was hospitalized by respondent on September 25, 1975, with a chief complaint of severe pain and numbness of right leg and foot. He had a history of a stroke with right hemiparesis in 1968. After performing a history and physical, respondent made a tentative diagnosis of hindbrain ischemia. On September 26, respondent had performed an aortic arch angiogram in which he found partial obstruction of origin and proximal right vertebral artery; the radiologist (Dr. Khani) founf tortuosity in the course of both vertebral arteries, both filled well with contrast material. On September 29, respondent performed surgery on the proximal right vertebral artery.

2. Respondent failed to perform or have performed an adequate neurological evaluation.

3. The angiography does not demonstrate any significant abnormality in the right vertebral artery.

4. On September 30, respondent noted: "pain right leg and foot gone." On discharge of October 2, respondent recorded patient's response to treatment as "Excellent - striking."

U. (B. P.)

1. Patient U, a 32 year-old woman, was hospitalized by respondent on July 29, 1975, with a chief complaint of severe hindbrain ischemia - 1 year, and a history of equilibrium disorder, dizziness, slurred speech, numbness and weakness of left arm, headache for 2 years and postural dizziness for 18 years. On July 30, respondent's tentative diagnosis was hindbrain ischemia, question partial obstruction vertebral artery. On July 30, he had performed an aortic arch angiogram in which he found partial obstructio of origin and proximal left vertebral artery with delayed filling; the radiologist (Dr. Khani) found both

vertebral arteries filled well with contrast material, origins of vertebral arteries intact with no evidence of obstruction. On August 1, respondent performed surgery on the left vertebral artery.

2.Respondent failed to perform or to have performed an adequate neurological evaluation.

3. The angiography does not show obstruction of the left vertebral artery.

4. On discharge of August 5, respondent noted patient's response to treratment as "Excellent. Symptom complex much improved strikingly."

5. Patient U testified on December 8, 1980 that, after suffering for many years with the above-described symptoms and becoming frustrated and depressed because "no one could help", she experienced a marked improvement the day after the surgery and has had no recurrence of her symptoms.

V. (K. T.)

1. Patient V, a 27 year-old woman, was hospitalized by Drs. Steller and Slocum on

May 21, 1975, for a chief complaint of dizziness, headache and ataxia. After performing a physical examination, Dr. Slocum gave a tentative diagnosis of extraluminal left vertebral artery occlusion. On May 21 respondent, in consultation, gave a diagnosis of probable hindbrain ischemia. He noted that the patient had extensive neurological work-ups at UCLA Medical Center in 1971 and 1972 but made no mention of the findings. On May 22, on respondents orders, there was performed an aortic arch angiogram in which respondent found partial obstruction of origin and proximal left vertebral artery; the radiologist (Dr. Khani) found relatively delayed filling of the left vertebral artery, with suggestion of slight extrinsic pressure deformity at its origin. On May 22, respondent performed surgery on the left vertebral artery. A post-operative angiogram was performed on May 27, which respondent evaluated as showing patent origin and proximal left vertebral artery; the radiologist interpreted it as showing the

left vertebral artery straighter at its origin with less extrinsic pressure, as compared to the previous examination, still relatively slower filling of the left vertebral artery.

2. Respondent failed to perform or to have performed an adequate neurological evaluation or to seek information regarding results of previous neurological studies.

3. On discharge of May 29, respondent noted patient's response to trreatment as "Excellent. Improved vision, memory, balance."

4. Patient V testified on December 10, 1980 that she suffered from severe headaches, dizziness, fatigue and depression for about four years before her hospitalization, that these symptoms went away right after the surgery and have not recurred, that she now feels alert and energetic and, in general, very well.

VII

GENERAL FINDINGS

A. DIAGNOSTIC PROCEDURES AND DIAGNOSES

1. As to all patients, respondent failed to diagnose carefully, considering disease entities other than hindbrain ischemia (or vertebral-basilar artery insufficiency) consistent with signs and symptoms disclosed in the patient histories, examinations or consultant reports. In each case, he interpreted the angiographic studies as confirming the tentative or admitting diagnosis of hindbrain ischemia. When his reading of the angiography was not confirmed by the radiologist, or was contradicted by the radiologist, he failed to take reasonable measures to verify his diagnosis, as by obtaining another physician's opinion on the angiography or by ordering appropriate examinations and tests or by consulting with another physician on the diagnosis. When consultations were obtained, he paid insufficient attention to the consultant's findings and recommendations. Respondent's diagnoses were unduly influenced by preconceptions and lack objective support. Respondent's diagnostic approach, in which

vertebral-basilar artery insufficiency is seen as the exclusive cause of many kinds of symptom which can be caused by other disorders or disease entities, is sharply distinguishable from thorough differential analysis of symptoms which is the standard of medical practice. Respondent's omissions in diagnostic procedures were an extreme departure from the standard of medical practice in the community, constituting gross negligence.

2. As to all patients, the diagnoses of hindbrain ischemia are not justified by patient histories and examinations, or, except in a few instances, by angiography. The diagnoses show a lack of knowledge or skill in medicine, constituting incompetence.

B. ANGIOGRAPHIC INTERPRETATION

As to all patients, except A, D, L, S and V, respondent's readings of angiograms are evidently incorrect, many of them so different from the hospital radiologists, or of expert witnesses, that respondent's skill or his objectivity, or both, are compromised.

In one instance (Patient M) he interpreted the post-operative angiogram as showing improvement in the condition of the left vertebral artery, when he had not operated on that artery, but, by mistake, on another nearby blood vessel. His theories evidently colored his perceptions, so that he frequently saw phenomena in angiograms which other physicians did not see and which, according to competent and credible evidence, are not there at all or are not present to a significant extent. His frequent erroneous readings of angiograms manifest a lack of knowledge or skill in medicine, constituting incompetence.

C. THE SURGERIES

1. As to all patients, respondent performed surgery which was not justified by medical histories or examinations and which was based on diagnoses negligently made or incorrect readings of angiograms, or both.

2. Respondent saw none of Dr. Khani's reports of angiography before performing surgery, relying on his own expertise in

interpreting the angiograms and on the patient's signs and symptoms.

3. In a large number of cases, the surgery resulted in no observable anatomic change or objectively verifiable increase in blood flow.

4. Successive surgery, first on one vertebral artery and then on the other, was performed in several cases, without any indication for or prospect of substantial benefit from the second surgery.

5. Respondent's performance of surgery shows, in these respects, a lack of knowledge or skill in medicine, constituting incompetence.

6. As to Patient G, respondent's performing surgery, when a heart attack was reported to be impending, was an extreme departure from the standard of practice, constituting gross negligence.

VIII

All allegations in the Accusations, not hereinabove found to be true, are found to be unproved or immaterial.

A. Respondent's opinions as to the commonness and importance of vertebral-basilar artery insufficiency find some support in other expert opinions. There is a strong contrary school of thought. Possession of an opinion, however strongly held, on a disputed matter, does not justify departure from the standard of practice as to diagnostic procedures or as to performance of surgery. Likewise, possession of an opinion on a disputed matter cannot excuse diagnoses not justified by information in patient medical records or misinterpretation of angiography or surgeries not indicated by objective standards.

B. The evidence of successful results in many of the 22 cases in question requires consideration. Respondent's observations of post-operative improvement in symptoms are corroborated by other treating physicians in certain cases and are entitled to weight; however, his observations are frequently couched in non-specific qualitative terms and

relate to short periods of time immediately following surgery; they are probably colored by his enthusiasm about the procedure and are not confirmed by evidence of significant anatomic changes or other objective data. In some of the cases, improvement could be expected because of natural recuperative processes or because of a placebo effect following surgery, or both. Subjective evidence coming from some patients or from their physicians makes it appear that respondent's treatment gave lasting benefit to some individuals. Such evidence of beneficial results in some cases does not validate a whole course of medical procedures and judgments, any more than evidence of poor results in some cases could invalidate it. Respondent's conduct must be judged by facts known or ascertainable at the time the conduct occurred.

* * * * *

Pursuant to the foregoing findings of fact, the Administrative Law Judge makes the following determination of issues:

I

Cause exists to suspend or revoke respondent's certificate pursuant to Sections 2360 and 2361, Business and Professions Code, in that he committed acts constituting unprofessional conduct, as follows:

1. Under Section 2361 (b) of said Code by reason of Findings of Fact VI, VII-A(1) and VII-C(6).

2. Under Section 2361 (d) of said Code by reason of Findings of Fact VI, VII-A(2), VII-B and VII-C(1) through (5).

II

In light of the whole record it would not be against the public interest to permit respondent to continue to practice medicine on certain terms and conditions hereinafter set forth.

* * * * *

WHEREFORE, THE FOLLOWING ORDER is hereby made:

As to each cause for discipline stated in the Determination of Issues, Physician's and Surgeon's Certificate No. G-3690,

heretofore issued to respondent Seymour Allan Hurvitz, M.D., is revoked; provided, however, execution of this order of revocation is stayed and respondent is placed on probation to the Division of Medical Quality of the Board of Medical Quality Assurance for a period of five (5) years beginning on the effective date of this Decision on the following terms and conditions:

1. Respondent shall obey all federal, state and local laws, and all rules and regulations governing the practice of medicine in California, including Section 1336, et seq. , Title 16, Administrative Code (Continuing Education).

2. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether or not there been compliance with all the conditions of probation.

3. Respondent shall comply with the Division's probation surveillance program.

4. Respondent shall appear in person for interviews with the Division's medical

consultant upon request at various intervals and with reasonable notice.

5. In the event respondent should leave California to reside or to practice outside the State, respondent shall notify the Division in writing of the dates of departure and return. Periods of residency or practice outside California will not apply to reduction of the probationary period.

6. Within 60 days of the effective date of this decision, respondent shall submit to the Division for its prior approval, a clinical education program related to the violations found in the decision. The exact number of hours and the specific content of the program shall be determined by the Division or its designee and shall total not less than four nor more than twenty hours per week for a period of not less than three months or more than two years. Respondent shall complete the clinical education program within two years and six months of the effective date of this decision. The Division or its designee may require the

respondent to pass an examination related to the content of the program.

7. Upon completion of the clinical education program, required by 6, above, respondent shall take and pass an oral clinical examination to be administered by the Division or its designee. If respondent fails this examination, respondent must wait three months between re-examinations, except that after three failures respondent must wait one year to take each necessary re-examination thereafter. The Division shall pay the costs of the first examination and respondent shall pay the costs of any subsequent examination.

8. During the first two (2) years of probation, respondent shall not perform any surgery on a vertebral artery unless he shall have first obtained an opinion, in writing, concurring in the surgery, from another qualified Board-certified thoracic and cardiac surgeon, who shall have been informed of the contents of this decision.

If respondent violates probation in any

respect, the Division, after giving respondent notice and opportunity to be heard, may vacate the stay order and impose the revocation of respondent's certificate or make such other order modifying the terms and conditions of probation as it deems just and reasonable in its discretion. Upon successful completion of probation, respondent's certificate shall be fully restored.

I hereby submit the foregoing which constitutes my Proposed Decision in the above-entitled matter, as a result of the hearing had before me on the above dates in Los Angeles, California, and recommend its adoption as the decision of the Division of Medical Quality, Board of Medical Quality Assurance.

/s/Kenneth Cameron

KENNETH CAMERON

Administrative Law Judge

Office of Administrative Hearings

DATED: June 3, 1981

CERTIFICATE OF SERVICE

I hereby certify that on this 15th day of October, 1985, three copies of the Petition for Writ of Certiorari were mailed, postage prepaid, to M. Gayle Askren, Esq., Deputy Attorney General, State of California, 110 West "A" Street, Suite 700, San Diego, California 92101, Counsel for the Respondent (California Board of Medical Quality Assurance). I further certify that all parties required to be served have been served.

S. Allan Hurvitz

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